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## INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS ASC 1-55 10M

## MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

11871

## CERTIFICATE OF DEATH

11867

Reg. Dist. No. 106

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <i>Charles</i>		MARYLAND		STATE <i>Maryland</i>		COUNTY <i>Charles</i>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <i>Indian Head</i>		<i>2 months</i>		TOWN <i>Indian Head</i>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <i>Jenkins Lane</i>				STREET ADDRESS (If rural give location) <i>Jenkins Lane</i>			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) <i>Burford</i> (Middle) <i>Gravelly</i> (Last) <i>Barlow</i>				(Month) <i>Dec.</i> (Day) <i>30</i> (Year) <i>1955</i>			
5. SEX <i>Female</i>	6. COLOR OR RACE <i>White</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <i>Widowed</i>	8. DATE OF BIRTH <i>Sept 12, 1886</i>	9. AGE last birthday <i>69</i> yrs.	IF UNDER 1 YEAR	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>own home</i>		11. BIRTHPLACE (State or foreign country) <i>Roanoke, Virginia</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.</i>	
13. FATHER'S NAME <i>Henry Clay Gravelly</i>				14. MOTHER'S MAIDEN NAME <i>Annie Turner</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <i>No</i>		16. SOCIAL SECURITY NO. <i>223-05-2680</i>		17. INFORMANT & ADDRESS <i>Mrs. R. B. Whitlock Indian Head, Md.</i>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						INTERVAL BETWEEN ONSET AND DEATH	
431X IMMEDIATE CAUSE (A) <i>Acute myocarditis</i>						<i>5 weeks.</i>	
ANTECEDENT CAUSE(S) DUE TO (B) <i>Fracture Right Shoulder</i>						<i>2 months</i>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) <i>Left sided Paralysis due to Cerebral Hemorrhage</i>						<i>2 yrs.</i>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town)		(County) (State)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. <i>Nov 29 1955</i>		21a. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <i>Nov 29 1955</i> , to <i>Dec 30 1955</i> , that I last saw the deceased alive on <i>Dec 29 1955</i> , and that death occurred at <i>140 P.M.</i> from the causes and on the date stated above.							
SIGNATURE <i>Frank A. Pusan</i> M.D.				ADDRESS (Street, city, town, state) <i>Indian Head, Md.</i>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>				DATE THEREOF <i>1-56</i>		NAME OF CEMETERY OR CREMATORY <i>Oakwood</i>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE <i>Mrs. Odey Price</i>		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS <i>Richmond, Virginia</i>	
DATE <i>JAN 4 1956</i>							



1

## INSTRUCTIONS

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VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

12579

## CERTIFICATE OF DEATH

Reg. Dist. No. 100

11872

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
COUNTY <i>Charles</i>		MARYLAND		STATE <i>md</i>		COUNTY <i>Charles</i>	
CITY (If outside corporate limits, write RURAL and give nearest town) <i>La Plata</i>		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) <i>La Plata</i>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <i>Physicians Memorial Hosp</i>				STREET ADDRESS (If rural give location)			
<b>3. NAME OF DECEASED</b> (Type or Print) <i>ELIZABETH BERRY</i>				<b>4. DATE OF DEATH</b> (Month) (Day) (Year) <i>Dec 31 1955</i>			
5. SEX <i>F</i>		6. COLOR OR RACE <i>W</i>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <i>Single</i>		8. DATE OF BIRTH <i>Oct 3 1874</i>	
				9. AGE last birthday <i>81</i> yrs.		IF UNDER 1 YEAR Months Days	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housework</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>None</i>		11. BIRTHPLACE (State or foreign country) <i>Maryland</i>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <i>George Berry</i>				14. MOTHER'S MAIDEN NAME <i>Maude Jane Cox</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <i>No</i>				16. SOCIAL SECURITY NO. <i>None</i>		17. INFORMANT & ADDRESS <i>William W Berry La Plata Md</i>	
<b>I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>						<b>18. MEDICAL CERTIFICATION</b>	
492x IMMEDIATE CAUSE (A) <i>Uremia</i>						INTERVAL BETWEEN ONSET AND DEATH <i>3 days</i>	
DUE TO ANTECEDENT CAUSE(S) (B) <i>Cardiovascular inadequacy</i>						<i>1 week</i>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) <i>Pneumonia</i>						<i>2 weeks</i>	
<b>II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.</b>							
19a. DATE OF OPERATION				19b. MAJOR FINDINGS OF OPERATION			
20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>							
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
<b>22. I hereby certify that I attended the deceased from</b> <i>15 Dec, 1955</i> , <b>to</b> <i>31 Dec, 1955</i> , <b>that I last saw the deceased alive on</b> <i>31 Dec, 1955</i> , <b>and that death occurred at</b> <i>10:30 AM</i> , <b>from the causes and on the date stated above.</b>							
<b>SIGNATURE</b> <i>F. M. Johnson</i> M.D.				<b>ADDRESS</b> (Street, city, town, state) <i>La Plata, Md</i>		<b>DATE SIGNED</b> <i>12-31-55</i>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>		DATE THEREOF <i>1-3-56</i>		NAME OF CEMETERY OR CREMATORY <i>Mt Rest Cemetery</i>		LOCATION (City, town, or county) (State) <i>La Plata Md</i>	
24. REC'D BY REGISTRAR DATE <i>1/4/56</i>		REGISTRAR'S SIGNATURE <i>Julia H. Pusey</i>		25. FUNERAL DIRECTOR'S SIGNATURE <i>Hunt &amp; Foul</i>		ADDRESS <i>Hunt &amp; Foul</i>	

BUREAU V. S.

JAN 9 1951

RECEIVED

1

INSTRUCTIONS

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VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

## CERTIFICATE OF DEATH

11868

11873

Reg. Dist. No. 100

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
COUNTY <u>Charles</u>		MARYLAND		STATE <u>Maryland</u> COUNTY <u>St. Mary's</u>			
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>LaPlata</u>		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Mechanicsville</u>		<u>18X-2</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>00</u>				STREET ADDRESS (If rural give location) <u>✓</u>			
<b>3. NAME OF DECEASED</b> (Type or Print)				<b>4. DATE OF DEATH</b>			
(First) <u>Infant</u> (Middle) <u>Boy</u> (Last) <u>Buckler</u>				(Month) <u>DECEMBER</u> (Day) <u>9</u> (Year) <u>1955</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Single</u>	8. DATE OF BIRTH <u>DECEMBER 9, 1955</u>	9. AGE last birthday <u>0</u> yrs.	IF UNDER 1 YEAR Months <u>0</u> Days <u>0</u>		IF UNDER 24 HRS. Hours <u>23</u> Min. <u>0</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Horace Buckler</u>				14. MOTHER'S MAIDEN NAME <u>Jeanette Wood</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS <u>Horace Buckler Mechanicsville, Md</u>			
<b>1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>				<b>15. MEDICAL CERTIFICATION</b>			
761.5 IMMEDIATE CAUSE (A) <u>RESPIRATORY ARREST</u>				INTERVAL BETWEEN ONSET AND DEATH <u>23 min.</u>			
ANTECEDENT CAUSE(S) DUE TO (B) <u>PREMATURITY (32 WEEKS)</u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) <u>ABRUPTIO PLACENTAE (MATERNAL)</u>							
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION <u>12/9/55</u>		19b. MAJOR FINDINGS OF OPERATION <u>CAESAREAN SECTION - ABRUPTIO PLACENTAE</u>		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. <input type="checkbox"/> Not while at work <input type="checkbox"/>		21e. INJURY OCCURRED While <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>12/9</u> , 19 <u>55</u> , to <u>12/9</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>12/9</u> , 19 <u>55</u> , and that death occurred at <u>9:50 P.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>John H. Griffin</u> M.D.				DATE SIGNED <u>Hughesville, Md. 12/9/55</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>12/10/55</u>		NAME OF CEMETERY OR CREMATORY <u>Mt. Zion</u>		LOCATION (City, town, or county) (State) <u>Oraville, Maryland</u>	
24. REC'D BY REGISTRAR DATE <u>12-12-55</u>		REGISTRAR'S SIGNATURE <u>Jos. C. Mattingley</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Jos. C. Mattingley</u> ADDRESS <u>Leonardtown, Md.</u>			

20V5202336

F. Hutto Bayo Davis



# CERTIFICATE OF DEATH

1198

Reg. Dist. No.

1. USUAL RESIDENCE (WORK OR BUSINESS)

MARYLAND

Chesapeake

1911

BUCKLER

Infant boy

1911

1911

1911

1911

BUREAU V. S.

DEC 13 1955

RECEIVED

1911

1911

RECEIVED

NOTICE TO THE PUBLIC: This is to certify that the above is a true and correct copy of the original record as it appears in the files of the State Department of Health, Baltimore, Maryland, and that the same has been compared with the original and found to be correct.

## MARYLAND STATE DEPARTMENT OF HEALTH

11869

11874

CERTIFICATE OF DEATH  
FOR MEDICAL EXAMINERS

Reg. Dist. No. 100

1. PLACE OF DEATH COUNTY <i>Charles</i>		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <i>md</i> COUNTY <i>Chas</i>	
CITY (If outside corporate limits, write RURAL and give nearest town) <i>Drayton</i>		CITY (If outside corporate limits, write RURAL and give nearest town) <i>Drayton</i>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS (If rural, give location)	
3. NAME OF DECEASED (Type or Print)	(First) <i>Louise</i> (Middle) <i>Roland</i> (Last) <i>CARROLL</i>	4. DATE OF DEATH	(Month) <i>12</i> (Day) <i>24</i> (Year) <i>1955</i>
5. SEX <i>M</i>	6. COLOR OR RACE <i>C</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <i>S</i>	8. DATE OF BIRTH <i>11-29-51</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE last birthday <i>26</i> yrs. If under 1 year Months <i>26</i> Days <i>26</i> Hours <i>26</i> Min.
11. BIRTHPLACE (State or foreign country) <i>md</i>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <i>Clarence Franklin</i>		14. MOTHER'S MAIDEN NAME <i>Julia Virginia Carroll</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY No.	
17. INFORMANT AND ADDRESS			

## 18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause (a) <i>Pneumonia</i>		<i>12-22-55</i>
Antecedent cause(s) (b) Diseases or conditions, if any, giving rise to the above cause, stating the underlying cause last		<i>1955</i>
(c)		

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
21. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	PLACE (Home, farm, factory, street, OF office hldg., etc.) INJURY	(CITY OR TOWN) (COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	HOW DID INJURY OCCUR?

22. I certify that I took charge of the remains described above, held an Autopsy ☐ Inspection ☒ Inquiry ☐ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☐ accident ☐ suicide ☐ homicide ☐ undetermined ☐.

SIGNATURE <i>L. Hedden</i>	(Degree or title) <i>md</i>	DATE SIGNED <i>12-24-55</i>
23. BURIAL, CREMATION OR REMOVAL (Specify)	DATE THEREOF <i>12/25/55</i>	NAME OF CEMETERY OR CREMATORY <i>Old Stone</i>
DATE REC'D BY LOCAL REG. <i>12/25/55</i>	REGISTRAR'S SIGNATURE <i>John H. Casey</i>	LOCATION (City, town, or county) <i>Drayton md.</i> (State)
24. FUNERAL DIRECTOR		ADDRESS <i>Roy Carroll, Drayton, md.</i>

40X5244427

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

DEC 23 1955

BUREAU V. S.

Julia Poay  
Mrs. Mills Poay



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## INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

## MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

## 11875 CERTIFICATE OF DEATH

11870

Reg. Dist. No. 100

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
COUNTY <u>CHARLES</u>		MARYLAND		STATE <u>Maryland</u> COUNTY <u>Charles</u>			
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>RURAL - SPRING HILL</u>		LENGTH OF STAY (in this place) <u>Lifetime</u>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Rural - Spring Hill</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>00</u>				STREET ADDRESS (If rural give location) <u>1</u>			
<b>3. NAME OF DECEASED</b> (Type or Print) <u>DANIAL THOMAS COLE</u>				<b>4. DATE OF DEATH</b> (Month) (Day) (Year) <u>Dec 3 1955</u>			
<b>5. SEX</b> <u>Male</u>	<b>6. COLOR OR RACE</b> <u>Colored</u>	<b>7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)</b> <u>Married</u>	<b>8. DATE OF BIRTH</b> <u>2 SEPT 1844</u>	<b>9. AGE last birthday</b> <u>111</u> Yrs.	<b>IF UNDER 1 YEAR</b> Months Days	<b>IF UNDER 24 HRS.</b> Hours Min.	
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>FARMER</u>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b>		<b>11. BIRTHPLACE</b> (State or foreign country) <u>MARYLAND</u>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>USA</u>	
<b>13. FATHER'S NAME</b> <u>unknown COLE</u>				<b>14. MOTHER'S MAIDEN NAME</b> <u>Emily Jenniter</u>			
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unk.) <u>No</u>		<b>16. SOCIAL SECURITY NO.</b> <u>NONE</u>		<b>17. INFORMANT &amp; ADDRESS</b> <u>Wife - Annie Cole.</u>			
<b>18. MEDICAL CERTIFICATION</b>						<b>INTERVAL BETWEEN ONSET AND DEATH</b>	
<b>I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>							
<b>1490X IMMEDIATE CAUSE (A)</b> <u>Respiratory failure</u>						<u>5 min</u>	
<b>ANTECEDENT CAUSE(S) DUE TO (B)</b> <u>Pneumonia, Lobar</u>						<u>3 days</u>	
<b>DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)</b> <u>Senile arterio sclerosis.</u>						<u>years</u>	
<b>11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.</b>							
<b>19a. DATE OF OPERATION</b>		<b>19b. MAJOR FINDINGS OF OPERATION</b>				<b>20. AUTOPSY?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
<b>21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)</b>		<b>21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)</b>		<b>21c. WHERE DID INJURY OCCUR?</b> (City or town) (County) (State)			
<b>21d. TIME OF INJURY</b> (Month) (Day) (Year) (Hour) (Min.)		<b>21a. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		<b>21f. HOW DID INJURY OCCUR?</b>			
<b>22. I hereby certify that I attended the deceased from</b> <u>Sept 1955</u> , <b>to</b> <u>3 Dec 1955</u> , <b>that I last saw the deceased alive on</b> <u>3 Dec 1955</u> , <b>and that death occurred at</b> <u>7:30 P.M.</u> , <b>from the causes and on the date stated above.</b>							
<b>SIGNATURE</b> <u>Stowooddy</u> M.D.				<b>ADDRESS</b> (Street, city, town, state) <u>La Plata, Md.</u>			
<b>DATE SIGNED</b> <u>4 Dec 55</u>							
<b>23. BURIAL, CREMATION, REMOVAL (SPECIFY)</b> <u>Burial</u>		<b>DATE THEREOF</b> <u>12-6-55</u>		<b>NAME OF CEMETERY OR CREMATORY</b> <u>St Marys</u>		<b>LOCATION</b> (City, town, or county) (State) <u>Newport Md</u>	
<b>24. REC'D BY REGISTRAR</b> <u>12/5/55</u>		<b>REGISTRAR'S SIGNATURE</b> <u>Julia H. Pacey</u>		<b>25. FUNERAL DIRECTOR'S SIGNATURE</b> <u>Beahm Funeral Home</u>		<b>ADDRESS</b> <u>La Plata Md</u>	

20070728

RECEIVED  
BUREAU OF HEALTH  
WASHINGTON, D.C.  
DEC 7 1955

# 1955 CERTIFICATE OF DEATH

MASSACHUSETTS DEPARTMENT OF HEALTH-BOSTON

1. NAME OF DECEASED		2. SEX		3. AGE		4. RACE		5. DATE OF DEATH		6. PLACE OF DEATH	
JAMES J. JONES		M		45		W		12/5/55		BOSTON, MASS.	
7. OCCUPATION		8. CAUSE OF DEATH		9. MANNER OF DEATH		10. MEDICAL EXAMINATION		11. SIGNATURE OF REGISTRAR		12. SIGNATURE OF DECEASED	
Carpenter		Heart Disease		Natural		None		[Signature]		[Signature]	
13. MEDICAL EXAMINATION		14. SIGNATURE OF PHYSICIAN		15. SIGNATURE OF SURGEON		16. SIGNATURE OF MIDWIFE		17. SIGNATURE OF NURSE		18. SIGNATURE OF OTHER	
None		[Signature]		[Signature]		[Signature]		[Signature]		[Signature]	
19. SIGNATURE OF REGISTRAR		20. SIGNATURE OF DECEASED		21. SIGNATURE OF SURVIVOR		22. SIGNATURE OF OTHER		23. SIGNATURE OF OTHER		24. SIGNATURE OF OTHER	
[Signature]		[Signature]		[Signature]		[Signature]		[Signature]		[Signature]	

BUREAU V. S.

DEC 7 1955

RECEIVED

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## INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

11871

11876

## CERTIFICATE OF DEATH

Reg. Dist. No. 100

1. PLACE OF DEATH COUNTY <u>CHARLES</u> MARYLAND CITY OR TOWN <u>LA PLATA</u> (If outside corporate limits, write RURAL and give nearest town) HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>PHYSICIANS MEMORIAL HOSPITAL</u>				2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Maryland</u> COUNTY <u>Charles</u> CITY OR TOWN <u>Rural: Tompkinsville</u> (If rural give location)			
3. NAME OF DECEASED (Type or Print) <u>Albert H. COPHER</u>			4. DATE OF DEATH (Month) <u>Dec</u> (Day) <u>13</u> (Year) <u>1955</u>				
5. SEX <u>Male</u>	6. COLOR OR RACE <u>W-OS</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widowed</u>	8. DATE OF BIRTH <u>March 9, 1972</u>	9. AGE last birthday <u>83</u> yrs.	10. IF UNDER 1 YEAR Months Days	11. IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>William Copher</u>			14. MOTHER'S MAIDEN NAME <u>Lucy</u>				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS <u>Mrs. Helen Hayden Dahlgren, Va.</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH	
442X IMMEDIATE CAUSE (A) <u>Respiratory Collapse</u>						<u>15 min</u>	
ANTECEDENT CAUSE(S) DUE TO (B) <u>Pneumonia</u>						<u>10 days</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) <u>Senile arteriosclerosis with heart &amp; kidney disease</u>						<u>4 years</u>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year)		21e. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>June</u> , 19 <u>49</u> , to <u>13 Dec</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>13 Dec</u> , 19 <u>55</u> , and that death occurred at <u>6:55 A.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>How Woody</u>		M.D. <u>La Plata</u>		DATE SIGNED <u>13 Dec 55</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>12/14/55</u>		NAME OF CEMETERY OR CREMATORY <u>Holy Ghost</u>			
24. REC'D BY REGISTRAR <u>Julia H. Gray</u>		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE <u>Archibald Funeral Home, La Plata, Md</u>			
DATE <u>12/14/55</u>				ADDRESS			

# CERTIFICATE OF DEATH

DATE OF DEATH

1. NAME OF DECEASED

2. SEX  
3. AGE  
4. OCCUPATION  
5. PLACE OF BIRTH

6. MARITAL STATUS

7. COLOR

8. RELIGION

9. EDUCATION

10. SERVICE

11. PLACE OF DEATH

12. CAUSE OF DEATH

13. MANNER OF DEATH

14. PLACE OF INTERMENT

15. SIGNATURE OF DECEASED

16. SIGNATURE OF WITNESSES

17. SIGNATURE OF PHYSICIAN

18. SIGNATURE OF CLERK

19. SIGNATURE OF REGISTRAR

20. SIGNATURE OF JUDGE

21. SIGNATURE OF SHERIFF

22. SIGNATURE OF CONSTABLE

23. SIGNATURE OF TOWNSHIP CLERK

24. SIGNATURE OF COUNTY CLERK

25. SIGNATURE OF STATE CLERK

26. SIGNATURE OF PRESIDENT

27. SIGNATURE OF VICE PRESIDENT

28. SIGNATURE OF SENATOR

29. SIGNATURE OF REPRESENTATIVE

30. SIGNATURE OF JUDGE OF THE PEACE

31. SIGNATURE OF JUSTICE OF THE SUPREME COURT

32. SIGNATURE OF ATTORNEY GENERAL

33. SIGNATURE OF COMMISSIONER OF THE GENERAL LAND OFFICE

34. SIGNATURE OF COMMISSIONER OF THE DEPARTMENT OF AGRICULTURE

35. SIGNATURE OF COMMISSIONER OF THE DEPARTMENT OF COMMERCE

36. SIGNATURE OF COMMISSIONER OF THE DEPARTMENT OF EDUCATION

37. SIGNATURE OF COMMISSIONER OF THE DEPARTMENT OF HEALTH

38. SIGNATURE OF COMMISSIONER OF THE DEPARTMENT OF LABOR

39. SIGNATURE OF COMMISSIONER OF THE DEPARTMENT OF MINES

40. SIGNATURE OF COMMISSIONER OF THE DEPARTMENT OF NATURAL RESOURCES

41. SIGNATURE OF COMMISSIONER OF THE DEPARTMENT OF PUBLIC SAFETY

42. SIGNATURE OF COMMISSIONER OF THE DEPARTMENT OF TRANSPORTATION

43. SIGNATURE OF COMMISSIONER OF THE DEPARTMENT OF UTILITIES

44. SIGNATURE OF COMMISSIONER OF THE DEPARTMENT OF WAREHOUSES

45. SIGNATURE OF COMMISSIONER OF THE DEPARTMENT OF WATER

46. SIGNATURE OF COMMISSIONER OF THE DEPARTMENT OF WILDLIFE

47. SIGNATURE OF COMMISSIONER OF THE DEPARTMENT OF ZOOLOGICAL GARDENS

48. SIGNATURE OF COMMISSIONER OF THE DEPARTMENT OF BOTANICAL GARDENS

49. SIGNATURE OF COMMISSIONER OF THE DEPARTMENT OF AERONAUTICS

50. SIGNATURE OF COMMISSIONER OF THE DEPARTMENT OF NAVY

51. SIGNATURE OF COMMISSIONER OF THE DEPARTMENT OF AIR FORCE

52. SIGNATURE OF COMMISSIONER OF THE DEPARTMENT OF COAST AND GEODYSY

53. SIGNATURE OF COMMISSIONER OF THE DEPARTMENT OF MARINE

54. SIGNATURE OF COMMISSIONER OF THE DEPARTMENT OF METEOROLOGY

55. SIGNATURE OF COMMISSIONER OF THE DEPARTMENT OF ASTRONOMY

56. SIGNATURE OF COMMISSIONER OF THE DEPARTMENT OF PHYSICS

57. SIGNATURE OF COMMISSIONER OF THE DEPARTMENT OF CHEMISTRY

58. SIGNATURE OF COMMISSIONER OF THE DEPARTMENT OF BIOLOGY

59. SIGNATURE OF COMMISSIONER OF THE DEPARTMENT OF MEDICINE

60. SIGNATURE OF COMMISSIONER OF THE DEPARTMENT OF DENTISTRY

61. SIGNATURE OF COMMISSIONER OF THE DEPARTMENT OF VETERINARY MEDICINE

62. SIGNATURE OF COMMISSIONER OF THE DEPARTMENT OF AGRICULTURE

BUREAU V. E.

DEC 16 1955

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I  
INSTRUCTIONS  
TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.  
VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

11872

11877 **CERTIFICATE OF DEATH**

Reg. Dist. No. 100

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
COUNTY <u>Charles</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Charles</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>La Plata</u>		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Bel Alton</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Physicians Memorial Hospital</u>				STREET ADDRESS (If rural give location)			
<b>3. NAME OF DECEASED</b> (Type or Print) (First) (Middle) (Last) <u>DORSEY</u>				<b>4. DATE OF DEATH</b> (Month) (Day) (Year) <u>12 14 55</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>C</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH <u>12-10-55</u>	9. AGE last birthday yrs.	IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>John Eugene Dorsey</u>				14. MOTHER'S MAIDEN NAME <u>Estelle Henrietta Hawkins</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS <u>John Dorsey</u> <u>Bel Alton, Maryland</u>			
<b>I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>				<b>18. MEDICAL CERTIFICATION</b>			
776X IMMEDIATE CAUSE (A) <u>Permaternity</u>				INTERVAL BETWEEN ONSET AND DEATH <u>3 day</u>			
ANTECEDENT CAUSE(S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE							
STATING UNDERLYING CAUSE LAST. DUE TO							
(C)							
<b>II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.</b>							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>12-10</u> 19 <u>55</u> , to <u>12-14</u> 19 <u>55</u> , that I last saw the deceased alive on <u>12-13</u> 19 <u>55</u> , and that death occurred at <u>8:00</u> A.M. from the causes and on the date stated above.							
SIGNATURE <u>JM Johnson</u>		M.D. <u>La Plata, Md</u>		ADDRESS (Street, city, town, state) <u>12-14-55</u>		DATE SIGNED	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>12/15/55</u>		NAME OF CEMETERY OR CREMATORY <u>Newtown</u>		LOCATION (City, town, or county) (State) <u>Spring Hill, Md</u>	
24. REC'D BY REGISTRAR DATE <u>12/15/55</u>		REGISTRAR'S SIGNATURE <u>Julia H. Paray</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>John E. Dorsey</u>		ADDRESS <u>Bel Alton, Md</u>	

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DEC 18 1955  
BUREAU V. S.

# CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE 15

Reg. Dist. No.

2 - A - VALLERHOLM FOR RECORD OF RECORDS

PLACE FOR SIGNATURE

DATE

DECEASED

AGE

SEX

RACE

PLACE FOR SIGNATURE

Physician (Name and Address)

DECEASED

12-16-55

DATE

AGE

Physician (Name and Address)

DECEASED

12-16-55

Physician (Name and Address)

Physician (Name and Address)

BUREAU V. S.

DEC 18 1955

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## INSTRUCTIONS

1

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

11873

## 11878 CERTIFICATE OF DEATH

Reg. Dist. No. 100

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
COUNTY <u>Bhadesia</u>		MARYLAND		STATE <u>Md.</u>		COUNTY <u>C. Hades</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>La Plata</u>		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>W. Victoria</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Physician Memorial Hospital</u>				STREET ADDRESS (If rural give location) <u>1</u>			
<b>3. NAME OF DECEASED</b> (Type or Print) <u>GEORGE AUBREY FORD</u>				<b>4. DATE OF DEATH</b> (Month) <u>12</u> (Day) <u>19</u> (Year) <u>1955</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>E</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>S</u>	8. DATE OF BIRTH <u>3-15-55</u>	9. AGE last birthday yrs. <u>9</u>	IF UNDER 1 YEAR Months <u>9</u> Days <u></u>		IF UNDER 24 HRS. Hours <u></u> Min. <u></u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Infant</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Thomas William Ford</u>				14. MOTHER'S MAIDEN NAME <u>Elsie Cecelia Miles</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>1</u>		16. SOCIAL SECURITY NO. <u></u>		17. INFORMANT & ADDRESS <u>Thomas W. Ford, W. Victoria</u>			
<b>I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>				<b>18. MEDICAL CERTIFICATION</b>			
571.0 IMMEDIATE CAUSE (A) <u>dehydration and vascular collapse</u>				INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u>			
ANTECEDENT CAUSE(S) DUE TO (B) <u>enteritis - probably Virus</u>				<u>1 week</u>			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C) <u></u>							
<b>II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.</b>							
19a. DATE OF OPERATION <u></u>		19b. MAJOR FINDINGS OF OPERATION <u></u>		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. <u></u>		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? <u></u>			
<b>22. I hereby certify that I attended the deceased from</b> <u>16 Dec</u> , 19 <u>55</u> , to <u>19 Dec</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>18 Dec</u> , 19 <u>55</u> , and that death occurred at <u>3:00</u> AM, from the causes and on the date stated above.							
SIGNATURE <u>F M Johnson</u>				DATE SIGNED <u>12-19-55</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>				DATE THEREOF <u>12-21-55</u>		NAME OF CEMETERY OR CREMATORY <u>Holy Ghost</u>	
24. REC'D BY REGISTRAR <u>Julia H. Pacey</u>		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE <u>Horath Funeral Home</u>		ADDRESS <u>Waldorf Md</u>	
DATE <u>12/21/55</u>							

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11871

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE 12

# CERTIFICATE OF DEATH

Form No. 1

1. NAME OF DECEASED (Print or Type)

2. SEX (Male or Female)

3. AGE (Years)

4. DATE OF BIRTH

5. PLACE OF BIRTH

6. OCCUPATION

7. CAUSE OF DEATH

8. PLACE OF DEATH

9. TIME OF DEATH

10. SIGNATURE OF PHYSICIAN

11. SIGNATURE OF REGISTRAR

12. SIGNATURE OF WITNESSES

13. SIGNATURE OF DECEASED

14. SIGNATURE OF DECEASED

15. SIGNATURE OF DECEASED

16. SIGNATURE OF DECEASED

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25. SIGNATURE OF DECEASED

BUREAU V. S.

DEC 28 1955

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1. NAME OF DECEASED (Print or Type)  
2. SEX (Male or Female)  
3. AGE (Years)  
4. DATE OF BIRTH  
5. PLACE OF BIRTH  
6. OCCUPATION  
7. CAUSE OF DEATH  
8. PLACE OF DEATH  
9. TIME OF DEATH  
10. SIGNATURE OF PHYSICIAN  
11. SIGNATURE OF REGISTRAR  
12. SIGNATURE OF WITNESSES  
13. SIGNATURE OF DECEASED  
14. SIGNATURE OF DECEASED  
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23. SIGNATURE OF DECEASED  
24. SIGNATURE OF DECEASED  
25. SIGNATURE OF DECEASED

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## INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

## MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

## 11879 CERTIFICATE OF DEATH

11874

Item 1. Film G191 1-5-56 et

Reg. Dist. No. ....

1. PLACE OF DEATH COUNTY <u>Charles</u> MARYLAND CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Bryantown</u> HOSPITAL OR INSTITUTION OR STREET ADDRESS		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Maryland</u> COUNTY <u>Charles</u> CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Bryantown</u> STREET ADDRESS (If rural give location)	
3. NAME OF DECEASED (Type or Print) (First) <u>John</u> (Middle) <u>WALTER</u> (Last) <u>Ford</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>12</u> <u>23</u> <u>1955</u>	
5. SEX <u>M.</u>	6. COLOR OR RACE <u>Black</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>SINGLE</u>	8. DATE OF BIRTH <u>3</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>NONE</u>		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE last birthday <u>65</u> yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.
11. BIRTHPLACE (State or foreign country) <u>Mass to Md</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>UNKNOWN</u>		14. MOTHER'S MAIDEN NAME <u>UNKNOWN</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT & ADDRESS <u>Bryantown Md.</u>		18. MEDICAL CERTIFICATION I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH 331X IMMEDIATE CAUSE (A) <u>Cerebral Hemorrhage</u> ANTECEDENT CAUSE(S) DUE TO <u>Hypertension</u> DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (B) <u>new Nov 1955</u> (C) II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		21. INTERVAL BETWEEN ONSET AND DEATH <u>12-23-55</u>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)		21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Minute) M. <input type="checkbox"/> Not while at work <input type="checkbox"/>	
21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>Nov 15</u> , to <u>Nov 23</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>Nov 15</u> , 19 <u>55</u> , and that death occurred at <u>7:24</u> M, from the causes and on the date stated above. SIGNATURE <u>J. J. J. J.</u> M. D. <u>Jab Kato</u> DATE SIGNED <u>12-23-55</u> ADDRESS (Street, city, town, state)			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u> DATE THEREOF <u>12/27/55</u>		NAME OF CEMETERY OR CREMATORY <u>St. Mary's Church</u> LOCATION (City, town, or county) <u>Bryantown Md.</u> (State)	
24. REC'D BY REGISTRAR <u>12-27-55</u> REGISTRAR'S SIGNATURE <u>M. L. Jones</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Berry &amp; Sons</u> ADDRESS <u>Bryantown Md.</u>	

01/10/2000

Top Waller Lot

Charles Howard  
Hypertension

BUREAU V. S.

DEC 28 1955

RECEIVED

*Handwritten signature*

127

11/11/11



1

## INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11875

11880

## CERTIFICATE OF DEATH

Reg. Dist. No. 100

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
COUNTY <i>Charles</i>		STATE <i>Md</i>		COUNTY <i>Charles</i>			
CITY (If outside corporate limits, write RURAL and give nearest town)		CITY (If outside corporate limits, write RURAL and give nearest town)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <i>Rural Charles</i>		TOWN <i>Rural</i>		TOWN <i>Waldorf</i>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS		(If rural give location)			
<b>3. NAME OF DECEASED</b> (Type or Print)				<b>4. DATE OF DEATH</b> (Month) (Day) (Year)			
<i>EDWIN MARY GARDINER</i>				<i>12 10 1955</i>			
5. SEX <i>M</i>	6. COLOR OR RACE <i>W</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <i>M</i>	8. DATE OF BIRTH <i>3-18-69</i>	9. AGE last birthday <i>86</i> yrs.	IF UNDER 1 YEAR		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Farmer</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Farming</i>		11. BIRTHPLACE (State or foreign country) <i>Maryland</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.</i>	
13. FATHER'S NAME <i>George Sylvester Gardiner</i>				14. MOTHER'S MAIDEN NAME <i>Mary Agnes Bowling</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>No</i>		17. INFORMANT & ADDRESS <i>Mrs Mitchell Cochran LaPlata Md</i>			
<b>18. MEDICAL CERTIFICATION</b>						<b>INTERVAL BETWEEN ONSET AND DEATH</b>	
<b>I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>							
450.0 IMMEDIATE CAUSE (A) <i>Acute Right Heart Failure</i>						<i>12-10-55</i>	
ANTECEDENT CAUSE(S) DUE TO (B) <i>Gen. Art. Sclerosis</i>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE DUE TO (C)							
<b>II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.</b>							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, or INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While et work <input type="checkbox"/> Not while et work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
<b>22. I hereby certify that I attended the deceased from</b> <i>12-10-55</i> <b>to</b> <i>12-10</i> <b>19</b> <i>55</i> <b>, that I last saw the deceased alive on</b> <i>12-10</i> <b>19</b> <i>55</i> <b>, and that death occurred at</b> <i>10</i> <b>M.</b> <b>from the causes and on the date stated above.</b>							
SIGNATURE <i>E. J. Edelen</i>				M.D. <i>LaPlata Md</i>		DATE SIGNED <i>12-10-55</i>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<i>Buried</i>		<i>12/13/55</i>		<i>St Peters</i>		<i>Waldorf Md</i>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
<i>12/13/55</i>		<i>Julia H. Roach</i>		<i>The Hunt Funeral Home</i>		<i>Waldorf, Md</i>	

RECEIVED

1

INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 104

## MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

11876

## 11881 CERTIFICATE OF DEATH

Reg. Dist. No. 100

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
COUNTY <b>Charles</b>		MARYLAND		STATE <b>Maryland</b>		COUNTY <b>Charles</b>	
CITY (If outside corporate limits, write RURAL OR and give nearest town) <b>La Plata</b>		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) <b>Indian Head</b>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <b>Physicians Memorial Hospital</b>				STREET ADDRESS (If rural give location) <b>24 Greenwood Pl. Potomac Heights</b>			
<b>3. NAME OF DECEASED</b> (Type or Print) <b>Everard Conard Gawthrop</b>				<b>4. DATE OF DEATH</b> (Month) <b>Dec.</b> (Day) <b>12</b> (Year) <b>19 55</b>			
<b>5. SEX</b> <b>M.</b>	<b>6. COLOR OR RACE</b> <b>W.</b>	<b>7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)</b> <b>Married</b>	<b>8. DATE OF BIRTH</b> <b>4-3-1886</b>	<b>9. AGE last birthday</b> <b>69</b> yrs.	<b>IF UNDER 1 YEAR</b> Months Days		<b>IF UNDER 24 HRS.</b> Hours Min.
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if done during most of working life, even if) <b>Elevator Maintenance Sup. U.S. Gov.</b>			<b>10b. KIND OF BUSINESS OR INDUSTRY</b>	<b>11. BIRTHPLACE</b> (State or foreign country) <b>West Grove, Penna.</b>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <b>US</b>	
<b>13. FATHER'S NAME</b> <b>Evan Gawthrop</b>				<b>14. MOTHER'S MAIDEN NAME</b> <b>Bertha Conard</b>			
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unk.) <b>No</b>		<b>16. SOCIAL SECURITY NO.</b> <b>None</b>		<b>17. INFORMANT &amp; ADDRESS</b> <b>Arthur N. Gawthrop</b>			
<b>I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>				<b>18. MEDICAL CERTIFICATION</b>			
<b>442X</b> IMMEDIATE CAUSE (A) <b>Congestive Heart Failure</b>				INTERVAL BETWEEN ONSET AND DEATH <b>1 yr.</b>			
ANTECEDENT CAUSE(S) DUE TO (B) <b>Arterio Sclerosis</b>				Indefinite			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) <b>Chronic Nephritis</b>				Indefinite			
<b>11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.</b> <b>Diabetia Melitus - Controlled</b>				Indefinite			
<b>19a. DATE OF OPERATION</b>		<b>19b. MAJOR FINDINGS OF OPERATION</b>		<b>20. AUTOPSY?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
<b>21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)</b>		<b>21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)</b>		<b>21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)</b>			
<b>21d. TIME OF INJURY (Month) (Day) (Year)</b>		<b>21e. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/></b>		<b>21f. HOW DID INJURY OCCUR?</b>			
<b>22. I hereby certify that I attended the deceased from 2-15-1952, to 12-12-55, that I last saw the deceased alive on 12-12-55, and that death occurred at 2:10 P.M. from the causes and on the date stated above.</b>							
<b>SIGNATURE</b> <i>[Signature]</i>				<b>DATE SIGNED</b> <b>12-12-55</b>			
<b>23. BURIAL, CREMATION, REMOVAL (SPECIFY)</b> <b>Burial</b>				<b>DATE THEREOF</b> <b>12-15-55</b>		<b>NAME OF CEMETERY OR CREMATORY</b> <b>Fort Lincoln</b>	
<b>24. REC'D BY, REGISTRAR</b> <b>DATE</b> <b>12/13/55</b>				<b>REGISTRAR'S SIGNATURE</b> <i>[Signature]</i>		<b>25. FUNERAL DIRECTOR'S SIGNATURE</b> <b>W. W. Chambers, 1400 Chapin, Rd. Wash. D. C.</b>	
				<b>LOCATION (City, town, or county)</b> <b>Prince George County, Md.</b>		<b>ADDRESS</b>	

22-1000

1. The first step is to identify the problem or question that needs to be answered. This involves understanding the context and the specific requirements of the task.

1990

BUREAU V. S.

DEC 15 1955

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INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

## MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

11882

## CERTIFICATE OF DEATH

11877

Reg. Dist. No. 100

Item 7, FilmG190 12-27-55 et

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
COUNTY <u>Charles</u>		STATE <u>Maryland</u> COUNTY <u>Charles</u>		CITY (If outside corporate limits, write RURAL and give nearest town)		CITY (If outside corporate limits, write RURAL and give nearest town)	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		TOWN <u>Rock Point</u>		TOWN <u>X</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS (If rural give location)		STREET ADDRESS		STREET ADDRESS	
66 <u>Physicians Memorial Hospital</u>				1 <u>I</u>			
<b>3. NAME OF DECEASED</b> (Type or Print)				<b>4. DATE OF DEATH</b> (Month) (Day) (Year)			
<u>WALTER JACKSON</u>				<u>December 14 19 55</u>			
5. SEX <u>M</u>		6. COLOR OR RACE <u>W</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Single</u>		8. DATE OF BIRTH <u>Mar. 25, 1878</u>	
9. AGE last birthday <u>77</u> yrs.		10. KIND OF BUSINESS OR INDUSTRY <u>Retired</u>		11. BIRTHPLACE (State or foreign country) <u>Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>US</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>U.S. Navy</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Retired</u>			
13. FATHER'S NAME <u>?</u>				14. MOTHER'S MAIDEN NAME <u>?</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>WW I</u>				16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS	
<b>18. MEDICAL CERTIFICATION</b>				<b>19. DATE OF OPERATION</b>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				INTERVAL BETWEEN ONSET AND DEATH			
331X IMMEDIATE CAUSE (A) <u>Cerebrovascular accident</u>				3 days			
ANTECEDENT CAUSE(S) DUE TO (B) <u>arteriosclerosis</u>				10 years			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>							
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)		21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Minute) M. <input type="checkbox"/> Not while at work <input type="checkbox"/>	
21e. INJURY OCCURRED While <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?		21g. HOW DID INJURY OCCUR?		21h. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>13 Dec 55</u> , to <u>14 Dec 55</u> , that I last saw the deceased alive on <u>13 Dec 55</u> , and that death occurred at <u>4:30 P.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>J. M. Johnson</u> M.D.				DATE SIGNED <u>12-14-55</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>12/16/55</u>		NAME OF CEMETERY OR CREMATORY <u>Arlington Nat'l</u>		LOCATION (City, town, or county) (State) <u>Arlington, Va</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE <u>Julia H. Porey</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Archard Funeral Home</u>		ADDRESS <u>La Plata, Md</u>	
DATE <u>12/14/55</u>							





PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

11883

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11878  
Reg. Dist.

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

No. 100

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Charles</u>		MARYLAND		STATE <u>md</u>		COUNTY <u>Charles</u>	
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (In this place)		CITY (If outside corporate limits write RURAL and give nearest town) OR TOWN			
TOWN <u>White Plains</u>				TOWN <u>White Plains (rural)</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural, give location)			
3. NAME OF DECEASED: (Type or Print)				4. DATE OF DEATH			
(First) <u>James</u>		(Middle) <u>Calvert</u>		(Last) <u>Johnson Jr.</u>		(Month) <u>12</u> (Day) <u>16</u> (Year) <u>1955</u>	
5. SEX <u>M</u>	6. COLOR OR RACE: <u>C</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>W</u>	8. DATE OF BIRTH: <u>7-18-51</u>	9. AGE last birthday: <u>4</u> yrs.		10. IF UNDER 1 YEAR: Months Days	
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired): <u>Driver</u>		10b. KIND OF BUSINESS OR INDUSTRY: <u>none</u>		11. BIRTHPLACE (State or foreign country): <u>md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME: <u>James Johnson</u>				14. MOTHER'S MAIDEN NAME: <u>Dorothy Driver</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <u>no</u>		16. SOCIAL SECURITY No.: <u>MD</u>		17. INFORMANT & ADDRESS: <u>White Plains md</u>			
18. MEDICAL CERTIFICATION				INTERVAL BETWEEN ONSET AND DEATH			
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:				<u>12-16-55</u>			
Immediate cause (a) <u>Conflagration</u>							
DUE TO							
Antecedent cause(s) (b) <u>giving rise to the above cause</u>							
DUE TO							
stating underlying cause last (c)							
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION: <u>9/16/55</u>				19b. MAJOR FINDING OF OPERATION:			
20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>							
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY		21c. (City or town) (County) (State)			
21d. TIME (Month) (Day) (Year) (Hour) <u>12</u> <u>16</u> <u>55</u> <u>10</u>		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		21f. HOW DID INJURY OCCUR? <u>House burned</u>			
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
SIGNATURE <u>C. Hedeler</u>				CHIEF MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED <u>12-16-55</u>			
				DEPUTY MEDICAL EXAMINER <input type="checkbox"/>			
				ASSISTANT MEDICAL EXAM. <input type="checkbox"/>			
23. BURIAL, CREMATION, REMOVAL (Specify): <u>Burial</u>		DATE THEREOF: <u>12-19-55</u>		NAME OF CEMETERY OR CREMATORY: <u>St Pauls Cemetery</u>		LOCATION (City/town or county) (State): <u>Waldorf md</u>	
DATE REC'D BY LOCAL REG. <u>12/19/55</u>		REGISTRAR'S SIGNATURE: <u>Julia Hasey</u>		24. FUNERAL DIRECTOR: <u>Horn &amp; Found Home</u>		ADDRESS: <u>Waldorf md</u>	

BUREAU V. S.

DEC 22 1955

RECEIVED

*[Faint, mostly illegible handwritten text, possibly containing names and dates]*

*[Vertical text along the right edge, likely a filing or processing stamp]*

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

11884  
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11879  
Reg. Dist.

No. 100

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>Charles</u>	MARYLAND	STATE <u>md</u>	COUNTY <u>Charles</u>
CITY (If outside corporate limits, write RURAL OR and give nearest town) <u>White Plains</u>	LENGTH OF STAY (in this place)	CITY (If outside corporate limits write RURAL and give nearest town) <u>White Plains (rural)</u>	TOWN <u>(rural)</u>
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS (If rural, give location)	
3. NAME OF DECEASED: (Type or Print)		4. DATE OF DEATH	
(First) <u>CAROLINE</u> (Middle) <u>Reed</u> (Last) <u>Johnson</u>		(Month) <u>12</u> (Day) <u>16</u> (Year) <u>1955</u>	
5. SEX: <u>F</u>	6. COLOR OR RACE: <u>C</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>S</u>	8. DATE OF BIRTH: <u>5-14-50</u>
9. AGE last birthday: <u>5</u> yrs.		10. IF UNDER 1 YEAR: Months <u>  </u> Days <u>  </u> IF UNDER 24 HRS. Hours <u>  </u> Min. <u>  </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired): <u>none</u>		10b. KIND OF BUSINESS OR INDUSTRY: <u>none</u>	
11. BIRTHPLACE (State or foreign country): <u>md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME: <u>James Johnson</u>		14. MOTHER'S MAIDEN NAME: <u>Dorothy Driver</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service): <u>no</u>		16. SOCIAL SECURITY No.: <u>none</u>	
17. INFORMANT & ADDRESS: <u>James Johnson</u>		<u>White Plains md</u>	
18. MEDICAL CERTIFICATION			INTERVAL BETWEEN ONSET AND DEATH
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:			<u>12-16-55</u>
Immediate cause (a) <u>Conflagration</u> DUE TO			
Antecedent cause(s) (b) <u>  </u> DUE TO			
Diseases or conditions, if any, giving rise to the above cause stating underlying cause last (c) <u>  </u>			
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19a. DATE OF OPERATION: <u>12-19-55</u>		19b. MAJOR FINDING OF OPERATION:	
20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>			
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>	21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY)	21c. (City or town) (County) (State)	
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY <u>12 16 55 10</u>	21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	21f. HOW DID INJURY OCCUR? <u>House burned</u>	
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
SIGNATURE <u>R. Hedden</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED <u>12-16-55</u> DEPUTY MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAM. <input type="checkbox"/>	
23. BURIAL, CREMATION, REMOVAL (Specify): <u>Burial</u>	DATE THEREOF: <u>12-19-55</u>	NAME OF CEMETERY OR CREMATORY: <u>St Pauls Cemetery</u>	LOCATION (City, town, or county) (State): <u>Waldorf md</u>
DATE REC'D BY LOCAL REG. <u>12/19/55</u>	REGISTRAR'S SIGNATURE: <u>Julia H. Casey</u>	24. FUNERAL DIRECTOR: <u>North Funeral Home</u>	ADDRESS: <u>Waldorf md</u>

BUREAU V. S.

DEC 22 1955

RECEIVED



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

11885

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
**MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

11880

Reg. Dist.

No. 100

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>Charles</u>	MARYLAND	STATE <u>Md</u>	COUNTY <u>Charles</u>
CITY (If outside corporate limits, write RURAL OR and give nearest town) <u>White Plains</u>	LENGTH OF STAY (in this place)	CITY (If outside corporate limits write RURAL and give nearest town) <u>White Plains (rural)</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS (If rural, give location)	
3. NAME OF DECEASED:		4. DATE OF DEATH	
(First) <u>Peggy</u>	(Middle) <u>Elaine</u>	(Last) <u>Johnson</u>	(Month) <u>12</u> (Day) <u>16</u> (Year) <u>1955</u>
5. SEX: <u>F</u>	6. COLOR OR RACE: <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>W</u>	8. DATE OF BIRTH: <u>Feb 23 1949</u>
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired): <u>none</u>		10b. KIND OF BUSINESS OR INDUSTRY: <u>none</u>	9. AGE last birthday: <u>6</u> yrs. IF UNDER 1 YEAR: Months Days Hours Min. IF UNDER 24 HRS.
11. BIRTHPLACE (State or foreign country): <u>Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME: <u>James Johnson</u>		14. MOTHER'S MAIDEN NAME: <u>Dorothy Driver</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unk.) (If Yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY No.: <u>none</u>	
17. INFORMANT & ADDRESS: <u>James Johnson White Plains Md</u>			
18. MEDICAL CERTIFICATION			
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			INTERVAL BETWEEN ONSET AND DEATH
Immediate cause (a) <u>Cerebral thrombosis</u>			<u>12-16-55</u>
DUE TO			
Antecedent cause(s) (b) <u>giving rise to the above cause</u>			
DUE TO			
stating underlying cause last (c)			
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19a. DATE OF OPERATION: <u>12-16-55</u>		19b. MAJOR FINDING OF OPERATION:	
20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>			
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OF CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY)	21c. (City or town) (County) (State)	
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY <u>12 16 55</u>	21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	21f. HOW DID INJURY OCCUR? <u>House burned</u>	
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
SIGNATURE <u>R. E. Medelen</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED <u>12-16-55</u>	
		DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	
		ASSISTANT MEDICAL EXAM. <input type="checkbox"/>	
23. BURIAL, CREMATION, REMOVAL (Specify): <u>Burial</u>	DATE THEREOF: <u>12-19-55</u>	NAME OF CEMETERY OR CREMATORY: <u>St. Pauls Cemetery</u>	LOCATION (City, town, or county) (State): <u>Waldorf Md</u>
DATE REC'D BY LOCAL REG. <u>12/19/55</u>	REGISTRAR'S SIGNATURE: <u>Julia H. Basing</u>	24. FUNERAL DIRECTOR: <u>Hunt Funeral Home</u> ADDRESS: <u>Waldorf Md</u>	



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## INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

V5 A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

## 11886 CERTIFICATE OF DEATH

11881

Reg. Dist. No. 100

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
COUNTY <i>Chas</i>		MARYLAND		STATE <i>MD</i>		COUNTY <i>CHARLES</i>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
X TOWN <i>LA PLATA</i>				TOWN <i>LA PLATA</i>		X	
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
100				1			
<b>3. NAME OF DECEASED</b> (First) (Middle) (Last)				<b>4. DATE OF DEATH</b> (Month) (Day) (Year)			
<i>DAVID W JONES</i>				<i>Dec. 31 1955</i>			
<b>5. SEX</b>	<b>6. COLOR OR RACE</b>	<b>7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)</b>	<b>8. DATE OF BIRTH</b>	<b>9. AGE last birthday</b> yrs.	<b>IF UNDER 1 YEAR</b> Months Days	<b>IF UNDER 24 HRS.</b> Hours Min.	
<i>M</i>	<i>C</i>	<i>S</i>	<i>Dec. 13, 1955</i>		<i>13</i>		
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired)		<b>10b. KIND OF BUSINESS OR INDUSTRY</b>		<b>11. BIRTHPLACE</b> (State or foreign country)		<b>12. CITIZEN OF WHAT COUNTRY?</b>	
<i>NONE</i>				<i>MD</i>			
<b>13. FATHER'S NAME</b>				<b>14. MOTHER'S MAIDEN NAME</b>			
<i>William BROWN</i>				<i>Helen JONES</i>			
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unk.)		<b>16. SOCIAL SECURITY NO.</b>		<b>17. INFORMANT &amp; ADDRESS</b>			
<i>4720</i>				<i>Helen Jones</i>			
<b>I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>						<b>18. MEDICAL CERTIFICATION</b>	
<b>772.0 IMMEDIATE CAUSE (A)</b>						<b>INTERVAL BETWEEN ONSET AND DEATH</b>	
<i>Pneumonia</i>						<i>1 week</i>	
<b>ANTECEDENT CAUSE(S) DUE TO</b>							
<i>Malnutrition</i>						<i>3 weeks</i>	
<b>DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO</b>							
<b>(C)</b>							
<b>II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.</b>							
<b>19a. DATE OF OPERATION</b>				<b>19b. MAJOR FINDINGS OF OPERATION</b>			
<i>D</i>							
<b>21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)</b>		<b>21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)</b>		<b>21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)</b>			
<b>21d. TIME OF INJURY (Month) (Day) (Year) (Hour)</b>				<b>21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/></b>		<b>21f. HOW DID INJURY OCCUR?</b>	
<b>22. I hereby certify that I attended the deceased from <i>30 Dec</i>, 19 <i>55</i>, to <i>31 Dec</i>, 19 <i>55</i>, that I last saw the deceased alive on <i>31 Dec</i>, 19 <i>55</i>, and that death occurred at <i>5:30 P.M.</i>, from the causes and on the date stated above.</b>							
<b>SIGNATURE</b>				<b>ADDRESS (Street, city, town, state)</b>		<b>DATE SIGNED</b>	
<i>J. M. Johnson</i>				<i>La Plata, Md</i>		<i>12-31-55</i>	
M.D.							
<b>23. BURIAL, CREMATION, REMOVAL (Specify)</b>		<b>DATE THEREOF</b>		<b>NAME OF CEMETERY OR CREMATORY</b>		<b>LOCATION (City, town, or county) (State)</b>	
<i>Burial</i>		<i>1-2-56</i>		<i>Swed. Heart</i>		<i>La Plata, Md</i>	
<b>24. REC'D BY REGISTRAR</b>		<b>REGISTRAR'S SIGNATURE</b>		<b>25. FUNERAL DIRECTOR'S SIGNATURE</b>		<b>ADDRESS</b>	
<i>1-2-56</i>		<i>Julia H. Passey</i>		<i>William Brown, La Plata, Md</i>			

40V5345344

# 1956 CERTIFICATE OF DEATH

1. DECEASED PERSON'S NAME (PRINT OR TYPE)

2. SEX

3. PLACE OF DEATH

4. DATE OF DEATH

5. TIME OF DEATH

6. PLACE OF BIRTH

7. AGE

8. OCCUPATION

9. MARITAL STATUS

10. RACE

11. RELIGION

12. EDUCATION

13. SOCIAL SECURITY NUMBER

14. MANNER OF DEATH

15. CAUSE OF DEATH

16. SIGNATURE OF PHYSICIAN

17. SIGNATURE OF REGISTRAR

SECTION 100-101

1. DECEASED PERSON'S NAME (PRINT OR TYPE)  
2. SEX  
3. PLACE OF DEATH  
4. DATE OF DEATH  
5. TIME OF DEATH  
6. PLACE OF BIRTH  
7. AGE  
8. OCCUPATION  
9. MARITAL STATUS  
10. RACE  
11. RELIGION  
12. EDUCATION  
13. SOCIAL SECURITY NUMBER  
14. MANNER OF DEATH  
15. CAUSE OF DEATH  
16. SIGNATURE OF PHYSICIAN  
17. SIGNATURE OF REGISTRAR

BUREAU V. S.

JAN 4 1956

RECEIVED

1

INSTRUCTIONS

**1** **TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

## MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

11882

## 11887 CERTIFICATE OF DEATH

Reg. Dist. No. 106

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
COUNTY <i>Charles</i>		MARYLAND		STATE <i>Md.</i>		COUNTY <i>Charles</i>	
CITY (If outside corporate limits, write RURAL OR and give nearest town) <i>Pomonkey</i>		LENGTH OF STAY (In this place) <i>85 years</i>		CITY (If outside corporate limits, write RURAL and give nearest town) <i>Pomonkey</i>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <i>R.R. 1-Box 97 Indian Head</i>				STREET ADDRESS (If rural give location) <i>J</i>			
<b>3. NAME OF DECEASED</b> (Type or Print) <i>Annie Maria King</i>				<b>4. DATE OF DEATH</b> (Month) <i>Dec</i> (Day) <i>2</i> (Year) <i>1955</i>			
5. SEX <i>F</i>	6. COLOR OR RACE <i>Cole</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <i>Widowed</i>	8. DATE OF BIRTH <i>Feb 24, 1870</i>	9. AGE last birthday <i>85</i> yrs.	IF UNDER 1 YEAR Months _____ Days _____		IF UNDER 24 HRS. Hours _____ Min. _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Own Home</i>		11. BIRTHPLACE (State or foreign country) <i>Pomonkey, Md.</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.</i>	
13. FATHER'S NAME <i>James Campbell</i>				14. MOTHER'S MAIDEN NAME <i>Ann Black</i>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <i>No</i>		16. SOCIAL SECURITY NO. <i>—</i>		17. INFORMANT & ADDRESS <i>Bessie King, Pomonkey, Md.</i>			
<b>I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>						<b>INTERVAL BETWEEN ONSET AND DEATH</b>	
331X IMMEDIATE CAUSE (A) <i>Cerebral Hemorrhage</i>						<i>2 wks.</i>	
ANTECEDENT CAUSE(S) DUE TO (B) <i>Hypertension</i>						<i>4 yrs +</i>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE DUE TO (C) <i>None</i>							
<b>II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.</b>							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Minute) (M. at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		21e. INJURY OCCURRED		21f. HOW DID INJURY OCCUR?			
<b>22. I hereby certify</b> that I attended the deceased from <i>11/19, 1955</i> , to <i>12/2, 1955</i> , that I last saw the deceased alive on <i>11/30, 1955</i> , and that death occurred at <i>4 P.M.</i> from the causes and on the date stated above.							
SIGNATURE <i>Frank A. Pusam, M.D.</i>				ADDRESS (Street, city, town, state) <i>Indian Head, Md.</i>		DATE SIGNED <i>12-2-55</i>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>		DATE THEREOF <i>12-6-55</i>		NAME OF CEMETERY OR CREMATORY <i>St. Charles Catholic</i>		LOCATION (City, town, or county) (State) <i>Edmont, Md.</i>	
24. REC'D BY REGISTRAR <i>12-5-55</i>		REGISTRAR'S SIGNATURE <i>M. E. Parsons D.L.R.</i>		25. FUNERAL DIRECTOR'S SIGNATURE <i>Barnes &amp; Matthews</i>		ADDRESS <i>614-4" St. S.W.</i>	



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This is to certify that the within and foregoing is a true and correct copy of the original as the same appears in the files of the Bureau of Health Statistics of the State of Maryland.

# 1957 CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, MD

11281

1. NAME OF DECEASED

2. SEX

3. AGE

4. DATE OF DEATH

5. PLACE OF DEATH

6. CAUSE OF DEATH

7. MANNER OF DEATH

8. SIGNATURE OF REGISTRAR

9. SIGNATURE OF DECEASED

10. SIGNATURE OF WITNESSES

11. SIGNATURE OF PHYSICIAN

12. SIGNATURE OF CLERK

13. SIGNATURE OF JUDGE

14. SIGNATURE OF SHERIFF

15. SIGNATURE OF CORONER

16. SIGNATURE OF DISTRICT ATTORNEY

17. SIGNATURE OF COUNTY CLERK

18. SIGNATURE OF TOWNSHIP CLERK

19. SIGNATURE OF VILLAGE CLERK

20. SIGNATURE OF POSTMASTER

21. SIGNATURE OF SHERIFF

22. SIGNATURE OF CORONER

23. SIGNATURE OF DISTRICT ATTORNEY

24. SIGNATURE OF COUNTY CLERK

25. SIGNATURE OF TOWNSHIP CLERK

26. SIGNATURE OF VILLAGE CLERK

27. SIGNATURE OF POSTMASTER

28. SIGNATURE OF SHERIFF

29. SIGNATURE OF CORONER

30. SIGNATURE OF DISTRICT ATTORNEY

BUREAU V. S.

DEC 21 1955

RECEIVED

1

INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

11883

11888

## CERTIFICATE OF DEATH

Reg. Dist. No. 100

Item 4. Film G190 12-30-55 et

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <i>Charles</i>		MARYLAND		STATE <i>md</i>		COUNTY <i>Charles</i>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (In this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <i>Newburg</i>				TOWN <i>Newburg</i>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
3. NAME OF DECEASED (Type or Print) <i>Linda Ann Lewis</i> (First) (Middle) (Last)				4. DATE OF DEATH <i>December 18 19 55</i> (Month) (Day) (Year)			
5. SEX <i>Female</i>	6. COLOR OR RACE <i>Col</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <i>Single</i>	8. DATE OF BIRTH <i>Oct 1, 1955</i>	9. AGE last birthday <i>2</i> yrs. <i>17</i> months <i>17</i> days		IF UNDER 1 YEAR IF UNDER 24 HRS. (Months) (Days) (Hours) (Min.)	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <i>md</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
13. FATHER'S NAME <i>Thomas W Lewis</i>				14. MOTHER'S MAIDEN NAME <i>Mary C Dyson Lewis</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS <i>Mary C. Dyson Lewis</i>			
18. MEDICAL CERTIFICATION				INTERVAL BETWEEN ONSET AND DEATH			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
5710 IMMEDIATE CAUSE (A) <i>Pneumonia</i>				2 days			
ANTECEDENT CAUSE(S) DUE TO				7 days			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (B) <i>Acute Sepsis Enteritis</i>							
(C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, or INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that <i>Dec 16 55</i> attended the deceased from <i>Dec 16 55</i> to <i>Dec 17 19 55</i> , that I last saw the deceased alive on <i>Dec 16 55</i> , and that death occurred at <i>La Plata</i> from the causes and on the date stated above.							
SIGNATURE <i>William H. Kuntz</i>		M.D.		ADDRESS (Street, city, town, state) <i>La Plata</i>		DATE SIGNED <i>12/20/55</i>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>		DATE THEREOF <i>12/20/55</i>		NAME OF CEMETERY OR CREMATORY <i>St Marys</i>		LOCATION (City, town, or county) (State) <i>Newport md</i>	
24. REC'D BY REGISTRAR <i>Julia H. Carey</i>		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE <i>Rehoboth Funeral Home Inc</i>		ADDRESS <i>La Plata</i>	
DATE <i>12/22/55</i>							

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INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

11884

11889

## CERTIFICATE OF DEATH

Reg. Dist. No. 101

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
COUNTY <u>Charles</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Charles</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Rison</u>		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Rison</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>00</u>				STREET ADDRESS (if rural give location)			
<b>3. NAME OF DECEASED</b> (Type or Print) <u>Earl D. Maddox</u>				<b>4. DATE OF DEATH</b> (Month) (Day) (Year) <u>Dec. 27 19 55</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH <u>Feb. 20 1892</u>		9. AGE last birthday <u>63</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if Ret.) <u>Powder factory</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>U.S. Gov.</u>		11. BIRTHPLACE (State or foreign country) <u>Charles Co.</u>		12. CITIZEN OF WHAT COUNTRY? <u>US</u>
13. FATHER'S NAME <u>Joseph Maddox</u>				14. MOTHER'S MAIDEN NAME <u>Buelah Groves</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <u>no</u>			16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT & ADDRESS <u>Mrs. Earl D. Maddox, Rison, Md.</u>		
<b>I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>						<b>18. MEDICAL CERTIFICATION</b>	
420.1 IMMEDIATE CAUSE (A) <u>Coronary Occlusion</u>						INTERVAL BETWEEN ONSET AND DEATH <u>3 wks.</u>	
ANTECEDENT CAUSE(S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO							
(C) <u>Hypertensive Heart Disease</u>						<u>2 yrs.</u>	
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>None</u>							
19a. DATE OF OPERATION <u>0</u>		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. <input type="checkbox"/> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21e. INJURY OCCURRED		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Nov 29, 1955</u> , to <u>Dec. 27, 1955</u> , that I last saw the deceased alive on <u>Sept 23, 1955</u> , and that death occurred at <u>11 P</u> M, from the causes and on the date stated above.							
SIGNATURE <u>Frank G. Susan</u> M.D.				ADDRESS (Street, city, town, state) <u>Indian Head, Md.</u>		DATE SIGNED <u>12-28-55</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>Dec. 30 1955</u>		NAME OF CEMETERY OR CREMATORY <u>Chicamuxen M.E. Cemetery</u>		LOCATION (City, town, or county) (State) <u>Rison Md.</u>	
24. REC'D BY REGISTRAR <u>JAN 2 1956</u>		REGISTRAR'S SIGNATURE <u>Mrs. Mary L. Luthersland</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Huntt Funeral Home</u>		ADDRESS <u>Waldorf, Md.</u>	

THIS IS TO CERTIFY THAT THE FOLLOWING IS A TRUE AND CORRECT COPY OF THE ORIGINAL AS SUBMITTED TO THE BUREAU OF VITAL STATISTICS, BALTIMORE, MARYLAND, ON JANUARY 2, 1956.

# CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 10

100-100000

1. NAME OF DECEASED (PRINT OR TYPE)

2. SEX (M or F)

3. AGE (Years, Months, Days)

4. DATE OF DEATH

5. PLACE OF DEATH

6. CAUSE OF DEATH (List all causes, beginning with the immediate cause)

7. MANNER OF DEATH (Natural, Accidental, Suicide, Homicide, Undetermined)

8. SIGNATURE OF PHYSICIAN

9. SIGNATURE OF REGISTRAR

10. SIGNATURE OF WITNESSES

11. SIGNATURE OF CORONER

12. SIGNATURE OF JURY

13. SIGNATURE OF JUDGE

14. SIGNATURE OF CLERK

15. SIGNATURE OF NOTARY

16. SIGNATURE OF DECEASED

17. SIGNATURE OF NEXT OF KIN

18. SIGNATURE OF SURVIVOR

19. SIGNATURE OF OTHER

20. SIGNATURE OF OTHER

21. SIGNATURE OF OTHER

22. SIGNATURE OF OTHER

23. SIGNATURE OF OTHER

24. SIGNATURE OF OTHER

25. SIGNATURE OF OTHER

26. SIGNATURE OF OTHER

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30. SIGNATURE OF OTHER

31. SIGNATURE OF OTHER

32. SIGNATURE OF OTHER

33. SIGNATURE OF OTHER

34. SIGNATURE OF OTHER

BUREAU V. S.

JAN 2 1956

RECEIVED



1

## INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

## MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

11885

11890

## CERTIFICATE OF DEATH

Reg. Dist. No. 105

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
COUNTY <i>Charles</i>		MARYLAND		STATE <i>Md</i>		COUNTY <i>Charles</i>	
CITY (If outside corporate limits, write RURAL and give nearest town) <i>X</i> <i>Waldorf</i>		LENGTH OF STAY (in this place) <i>3 yrs.</i>		CITY (If outside corporate limits, write RURAL and give nearest town) <i>Waldorf</i>		<i>X</i>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
<b>3. NAME OF DECEASED</b> (First) (Middle) (Last) <i>ELLEN ELIZABETH (NELLIE SCHULER) McGRATH</i>				<b>4. DATE OF DEATH</b> (Month) (Day) (Year) <i>12 27 19 55</i>			
<b>5. SEX</b> <i>F</i>	<b>6. COLOR OR RACE</b> <i>W</i>	<b>7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)</b> <i>Widowed</i>	<b>8. DATE OF BIRTH</b> <i>9-12-96</i>		<b>9. AGE last birthday</b> <i>59</i> yrs.	<b>IF UNDER 1 YEAR</b> Months Days	<b>IF UNDER 24 HRS.</b> Hours Min.
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <i>Teacher</i>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <i>School (County)</i>		<b>11. BIRTHPLACE</b> (State or foreign country) <i>Lexington Ky</i>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <i>US</i>	
<b>13. FATHER'S NAME</b> <i>ALBERT SCHULER</i>				<b>14. MOTHER'S MAIDEN NAME</b> <i>MARIA HAMILTON</i>			
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unk.) (If Yes, give war or dates of service)		<b>16. SOCIAL SECURITY NO.</b> <i>577-09-5912</i>		<b>17. INFORMANT &amp; ADDRESS</b> <i>MRS EMIL KELLER</i>			
<b>I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>						<b>18. MEDICAL CERTIFICATION</b>	
<b>416X IMMEDIATE CAUSE (A)</b> <i>Sudden Dilatation of Heart</i>						<b>INTERVAL BETWEEN ONSET AND DEATH</b> <i>12-27-55</i>	
<b>ANTECEDENT CAUSE(S) DUE TO (B)</b> <i>RHEUMATIC HEART DISEASE</i>						<i>1948-55</i>	
<b>DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C)</b>							
<b>II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.</b>							
<b>19a. DATE OF OPERATION</b>		<b>19b. MAJOR FINDINGS OF OPERATION</b>				<b>20. AUTOPSY?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
<b>21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)</b>		<b>21b. PLACE (Home, farm, factory, OR INJURY street, office bldg., etc.)</b>		<b>21c. WHERE DID INJURY OCCUR?</b> (City or town) (County) (State)			
<b>21d. TIME OF INJURY</b> (Month) (Day) (Year) (Hour) (Min.)		<b>21e. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		<b>21f. HOW DID INJURY OCCUR?</b>			
<b>22. I hereby certify that I attended the deceased from</b> <i>1948</i> , <b>19</b> <i>12-27</i> , <b>19</b> <i>55</i> , <b>that I last saw the deceased alive on</b> <i>11-29</i> , <b>19</b> <i>55</i> , <b>and that death occurred at</b> <i>11</i> <b>M.</b> <b>from the causes and on the date stated above.</b>							
<b>SIGNATURE</b> <i>E. J. Edelen</i>				<b>ADDRESS</b> (Street, City, Town, State) <i>La Plata Md</i>		<b>DATE SIGNED</b> <i>12-27-55</i>	
<b>23. BURIAL, CREMATION, REMOVAL (SPECIFY)</b> <i>Burial</i>		<b>DATE THEREOF</b> <i>12-29-55</i>		<b>NAME OF CEMETERY OR CREMATORY</b> <i>Holy Rood Cemetery</i>		<b>LOCATION (City, Town, or county)</b> <i>Washington D.C.</i>	
<b>24. REC'D BY REGISTRAR</b> <i>DATE 12-28-55</i>		<b>REGISTRAR'S SIGNATURE</b> <i>M L Moore</i>		<b>25. FUNERAL DIRECTOR'S SIGNATURE</b> <i>Hunt Funeral Home</i>		<b>ADDRESS</b> <i>Waldorf Md</i>	

CERTIFICATE OF DEATH

Form No. 10

A. DEATH INFORMATION

B. CAUSE OF DEATH

1. NAME OF DECEASED

2. SEX

3. AGE

4. DATE OF BIRTH

5. PLACE OF BIRTH

6. OCCUPATION

7. MARITAL STATUS

8. RACE

9. RELIGION

10. EDUCATION

11. SOCIAL CLASS

12. MANNER OF DEATH

13. PLACE OF DEATH

14. TIME OF DEATH

15. SIGNATURE OF DECEASED

16. SIGNATURE OF WITNESSES

17. SIGNATURE OF PHYSICIAN

18. SIGNATURE OF CORONER

19. SIGNATURE OF JURY

20. SIGNATURE OF JUDGE

21. SIGNATURE OF CLERK

22. SIGNATURE OF REGISTRAR

23. SIGNATURE OF VENDOR

24. SIGNATURE OF SELLER

25. SIGNATURE OF BUYER

26. SIGNATURE OF OWNER

27. SIGNATURE OF LESSEE

28. SIGNATURE OF RENTER

29. SIGNATURE OF MORTGAGEE

30. SIGNATURE OF MORTGAGOR

31. SIGNATURE OF CREDITOR

32. SIGNATURE OF DEBTOR

33. SIGNATURE OF GUARANTOR

34. SIGNATURE OF INSURED

35. SIGNATURE OF POLICYHOLDER

36. SIGNATURE OF BENEFICIARY

37. SIGNATURE OF ESTATE

38. SIGNATURE OF TRUST

39. SIGNATURE OF FIDUCIARY

40. SIGNATURE OF AGENT

41. SIGNATURE OF ATTORNEY

42. SIGNATURE OF SHERIFF

43. SIGNATURE OF CONSTABLE

44. SIGNATURE OF JAILER

45. SIGNATURE OF PRISONER

46. SIGNATURE OF WARDEN

47. SIGNATURE OF CHIEF OF POLICE

48. SIGNATURE OF DETECTIVE

49. SIGNATURE OF PATROLMAN

50. SIGNATURE OF OFFICER

51. SIGNATURE OF SERGEANT

52. SIGNATURE OF CAPTAIN

53. SIGNATURE OF MAJOR

54. SIGNATURE OF COLONEL

55. SIGNATURE OF LIEUTENANT

56. SIGNATURE OF FIRST LIEUTENANT

57. SIGNATURE OF SECOND LIEUTENANT

58. SIGNATURE OF THIRD LIEUTENANT

59. SIGNATURE OF FOURTH LIEUTENANT

60. SIGNATURE OF FIFTH LIEUTENANT

61. SIGNATURE OF SIXTH LIEUTENANT

62. SIGNATURE OF SEVENTH LIEUTENANT

63. SIGNATURE OF EIGHTH LIEUTENANT

64. SIGNATURE OF NINTH LIEUTENANT

65. SIGNATURE OF TENTH LIEUTENANT

66. SIGNATURE OF ELEVENTH LIEUTENANT

67. SIGNATURE OF TWELFTH LIEUTENANT

68. SIGNATURE OF THIRTEENTH LIEUTENANT

69. SIGNATURE OF FOURTEENTH LIEUTENANT

70. SIGNATURE OF FIFTEENTH LIEUTENANT

71. SIGNATURE OF SIXTEENTH LIEUTENANT

72. SIGNATURE OF SEVENTEENTH LIEUTENANT

73. SIGNATURE OF EIGHTEENTH LIEUTENANT

74. SIGNATURE OF NINETEENTH LIEUTENANT

75. SIGNATURE OF TWENTIETH LIEUTENANT

76. SIGNATURE OF TWENTY-FIRST LIEUTENANT

77. SIGNATURE OF TWENTY-SECOND LIEUTENANT

78. SIGNATURE OF TWENTY-THIRD LIEUTENANT

79. SIGNATURE OF TWENTY-FOURTH LIEUTENANT

80. SIGNATURE OF TWENTY-FIFTH LIEUTENANT

81. SIGNATURE OF TWENTY-SIXTH LIEUTENANT

82. SIGNATURE OF TWENTY-SEVENTH LIEUTENANT

83. SIGNATURE OF TWENTY-EIGHTH LIEUTENANT

84. SIGNATURE OF TWENTY-NINTH LIEUTENANT

85. SIGNATURE OF THIRTIETH LIEUTENANT

86. SIGNATURE OF THIRTY-FIRST LIEUTENANT

87. SIGNATURE OF THIRTY-SECOND LIEUTENANT

88. SIGNATURE OF THIRTY-THIRD LIEUTENANT

89. SIGNATURE OF THIRTY-FOURTH LIEUTENANT

90. SIGNATURE OF THIRTY-FIFTH LIEUTENANT

91. SIGNATURE OF THIRTY-SIXTH LIEUTENANT

92. SIGNATURE OF THIRTY-SEVENTH LIEUTENANT

93. SIGNATURE OF THIRTY-EIGHTH LIEUTENANT

94. SIGNATURE OF THIRTY-NINTH LIEUTENANT

95. SIGNATURE OF FORTIETH LIEUTENANT

96. SIGNATURE OF FORTY-FIRST LIEUTENANT

97. SIGNATURE OF FORTY-SECOND LIEUTENANT

98. SIGNATURE OF FORTY-THIRD LIEUTENANT

99. SIGNATURE OF FORTY-FOURTH LIEUTENANT

100. SIGNATURE OF FORTY-FIFTH LIEUTENANT

101. SIGNATURE OF FORTY-SIXTH LIEUTENANT

102. SIGNATURE OF FORTY-SEVENTH LIEUTENANT

103. SIGNATURE OF FORTY-EIGHTH LIEUTENANT

104. SIGNATURE OF FORTY-NINTH LIEUTENANT

105. SIGNATURE OF FIFTIETH LIEUTENANT

106. SIGNATURE OF FIFTY-FIRST LIEUTENANT

107. SIGNATURE OF FIFTY-SECOND LIEUTENANT

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115. SIGNATURE OF SIXTIETH LIEUTENANT

116. SIGNATURE OF SIXTY-FIRST LIEUTENANT

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124. SIGNATURE OF SIXTY-NINTH LIEUTENANT

125. SIGNATURE OF SEVENTIETH LIEUTENANT

126. SIGNATURE OF SEVENTY-FIRST LIEUTENANT

127. SIGNATURE OF SEVENTY-SECOND LIEUTENANT

128. SIGNATURE OF SEVENTY-THIRD LIEUTENANT

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134. SIGNATURE OF SEVENTY-NINTH LIEUTENANT

135. SIGNATURE OF EIGHTIETH LIEUTENANT

136. SIGNATURE OF EIGHTY-FIRST LIEUTENANT

137. SIGNATURE OF EIGHTY-SECOND LIEUTENANT

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145. SIGNATURE OF NINETYETH LIEUTENANT

146. SIGNATURE OF NINETY-FIRST LIEUTENANT

147. SIGNATURE OF NINETY-SECOND LIEUTENANT

148. SIGNATURE OF NINETY-THIRD LIEUTENANT

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153. SIGNATURE OF NINETY-EIGHTH LIEUTENANT

154. SIGNATURE OF NINETY-NINTH LIEUTENANT

155. SIGNATURE OF HUNDRETH LIEUTENANT

156. SIGNATURE OF HUNDRED-FIRST LIEUTENANT

157. SIGNATURE OF HUNDRED-SECOND LIEUTENANT

158. SIGNATURE OF HUNDRED-THIRD LIEUTENANT

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235. SIGNATURE OF HUNDRETH LIEUTENANT

236. SIGNATURE OF HUNDRED-FIRST LIEUTENANT

237. SIGNATURE OF HUNDRED-SECOND LIEUTENANT

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243. SIGNATURE OF HUNDRED-EIGHTH LIEUTENANT

244. SIGNATURE OF HUNDRED-NINTH LIEUTENANT

245. SIGNATURE OF HUNDRETH LIEUTENANT

246. SIGNATURE OF HUNDRED-FIRST LIEUTENANT

11886

MUSCHETTE

MARYLAND STATE DEPARTMENT OF HEALTH  
11891 CERTIFICATE OF DEATH  
FOR MEDICAL EXAMINERS

Reg. Dist. No. 100

1. PLACE OF DEATH COUNTY <u>Charles</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>md.</u> COUNTY <u>Charles</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Laurel</u> LENGTH OF STAY (In this place) <u>2 1/2</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Laurel</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS (If rural, give location) <u>1</u>	
3. NAME OF DECEASED (First) <u>JAMES</u> (Middle) <u>QUENTON</u> (Last) <u>MUSCHETTE</u>		4. DATE OF DEATH (Month) <u>12</u> (Day) <u>4</u> (Year) <u>1955</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>C</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>S</u>	8. DATE OF BIRTH <u>9-8-55</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, or retired) <u>Infant</u>		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE last birthday <u>2</u> yrs. If under 1 year Months <u>26</u> Days <u>26</u> Hours <u>26</u> Min.
11. FATHER'S NAME <u>HENRY MUSCHETTE</u>		12. CITIZEN OF WHAT COUNTRY? <u>US</u>	
13. MOTHER'S MAIDEN NAME <u>BERENICE BARBER</u>		14. DATE OF BIRTH	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT AND ADDRESS <u>Henry Muschette</u>		18. MEDICAL CERTIFICATION	

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH
491X Immediate cause (a) <u>BRONCHO-PNEUMONIA</u>		<u>12-3-55</u>
Antecedent cause(s) (b) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c)		

11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>
21. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	(CITY OR TOWN) (COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	HOW DID INJURY OCCUR?

22. I certify that I took charge of the remains described above, held an Autopsy ☐ Inspection ☐ Inquiry ☐ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: (Natural causes ☐ accident ☐ suicide ☐ homicide ☐ undetermined ☐

SIGNATURE <u>[Signature]</u>	DATE SIGNED <u>12-4-55</u>
23. BURIAL, CREMATION OR DISPOSAL (Specify) <u>Burial</u>	DATE THEREOF <u>12/5/55</u>
NAME OF CEMETERY OR CREMATORY <u>Sacred Heart</u>	LOCATION (City, town, or county) (State) <u>Laurel, Md.</u>
DATE REC'D BY LOCAL REG. <u>12/5/55</u>	REGISTRAR'S SIGNATURE <u>[Signature]</u>
24. FUNERAL DIRECTOR <u>Henry Muschette</u>	ADDRESS <u>Laurel, Md.</u>

1095161387

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. S.

DEC 7 1955

RECEIVED

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11892

## CERTIFICATE OF DEATH

11887

Reg. Dist. No. 101

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
COUNTY <i>Charles</i>		MARYLAND		STATE <i>MD</i>		COUNTY <i>Charles</i>	
CITY (If outside corporate limits, write RURAL OR end give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
<i>x</i> TOWN <i>Marbury</i>		<i>30 yrs</i>		TOWN <i>Marbury</i>		<i>x</i>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
<i>00</i>							
<b>3. NAME OF DECEASED</b> (Type or Print)				<b>4. DATE OF DEATH</b> (Month) (Day) (Year)			
(First) (Middle) (Last)							
<i>Σ 1262th Mary Penny</i>				<i>Dec 1 1955</i>			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR	IF UNDER 24 HRS.	
<i>Female</i>	<i>Col.</i>	<i>widowed</i>	<i>April 4, 1886</i>	<i>69 yrs.</i>	Months	Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
<i>Housewife</i>		<i>Own Home</i>		<i>Charles County</i>		<i>U.S.</i>	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
<i>James Henry Swann</i>				<i>Josephine Chase</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
<i>none</i>		<i>none</i>		<i>Katie Swann. Marbury. MD.</i>			
<b>18. MEDICAL CERTIFICATION</b>							
<b>I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>							
331X IMMEDIATE CAUSE (A)		<i>Cerebral Hemorrhage</i>					
ANTECEDENT CAUSE(S) DUE TO		<i>Hypertension</i>					
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE DUE TO							
STATING UNDERLYING CAUSE LAST, (C)							
<b>II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.</b>							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION					
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, lecture, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> M. <input type="checkbox"/> et work <input type="checkbox"/> et work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <i>Nov. 2</i> , 19 <i>55</i> , to <i>Nov 30</i> , 19 <i>55</i> , that I last saw the deceased alive on <i>11/20</i> , 19 <i>55</i> , and that death occurred at <i>1 A</i> M, from the causes and on the date stated above.							
SIGNATURE <i>F A Osan</i>				ADDRESS (Street, city, town, state) <i>Indian Head MD</i>		DATE SIGNED <i>12-1-55</i>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<i>Burial</i>		<i>Dec. 1955</i>		<i>St. Charles</i>		<i>Glymont Md.</i>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
DATE <i>12/2/55</i>		<i>Mary Swithland</i>		<i>Stanley Penny</i>		<i>Mason Spgs. Md.</i>	



1  
SOUTHERN

RECEIVED  
DEC 7 1955  
BUREAU V. S.

15-111  
Dec 1922

BUREAU V. S.

DEC 7 1955

RECEIVED

James Henry Johnson  
born  
Charles County  
Md  
April, 1880

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE 10

11887

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

11893

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

**MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

11888  
Reg. Dist.

No. 195

1. PLACE OF DEATH: COUNTY <u>Charles</u> MARYLAND CITY (If outside corporate limits, write RURAL OR and give nearest town) <u>Waldorf (rural) Md</u> TOWN <u>Waldorf (rural) Md</u> HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>00</u>				2. USUAL RESIDENCE (HOME) OF DECEASED: STATE <u>md</u> COUNTY <u>Charles</u> CITY (If outside corporate limits write RURAL and give nearest town) <u>Accobee</u> TOWN <u>16X-2</u> STREET ADDRESS (If rural, give location)			
3. NAME OF DECEASED: (Type or Print) <u>STARLIN (First) (Middle) (Last) FRANKLIN Rickett</u>				4. DATE OF DEATH (Month) <u>12</u> (Day) <u>31</u> (Year) <u>1955</u>			
5. SEX: <u>M</u>		6. COLOR OR RACE: <u>W</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>2</u>			
8. DATE OF BIRTH: <u>10-10-38</u>		9. AGE last birthday: <u>17</u> yrs.		10. IF UNDER 1 YEAR: Months <u>12</u> Days <u>31</u>			
11. IF UNDER 24 HRS. Months <u>12</u> Days <u>31</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>		13. FATHER'S NAME: <u>Leonard Rickett</u>			
14. MOTHER'S MAIDEN NAME: <u>Marie Wilson</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <u>no</u> (If Yes, give war or dates of service)		16. SOCIAL SECURITY No.: <u>218-34-7406</u>			
17. INFORMANT & ADDRESS: <u>Shirley Rickett Accobee Md</u>		18. MEDICAL CERTIFICATION					
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH: Immediate cause (a) <u>822X FRAC SKULL</u> Antecedent cause(s) (b) <u>PROBABLE DROWNING</u> Diseases or conditions, if any, giving rise to the above cause stating underlying cause last (c) <u>CAR OVERTURNED IN CREEK</u>				INTERVAL BETWEEN ONSET AND DEATH <u>12-31-55</u>			
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>PINNING BY BENEATH CAR</u>				12-31-55			
19a. DATE OF OPERATION: <u>8</u>		19b. MAJOR FINDING OF OPERATION:		20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH.		21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY <u>Accobee</u> )		21c. (City or town) (County) <u>CHARLES MD</u> (State)			
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY <u>12 31 55</u>		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		21f. HOW DID INJURY OCCUR? <u>AUTO OVERTURNED</u>			
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
SIGNATURE <u>E. Edelen</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED <u>12-31-55</u> DEPUTY MEDICAL EXAMINER <input type="checkbox"/> M. D. ASSISTANT MEDICAL EXAM. <input type="checkbox"/>					
23. BURIAL, CREMATION, REMOVAL (Specify): <u>Burial</u>		DATE THEREOF: <u>1-4-56</u>		NAME OF CEMETERY OR CREMATORY: <u>Shiloh M.E. Cemetery</u>			
LOCATION (City, town, or county) (State): <u>Bryan's Road Md</u>		DATE REC'D BY LOCAL REG. <u>1-3-56</u>		REGISTRAR'S SIGNATURE: <u>M. D. Mours</u>			
24. FUNERAL DIRECTOR: <u>Wintt Funeral Home</u>		ADDRESS: <u>Waldorf Md</u>					

MINISTRE DES TRAVAUX PUBLICS  
DEPARTMENT OF PUBLIC WORKS  
CERTIFICATE OF DEATH

STANLEY FRANKLIN BICKETT

M 10 2 10-11-38 17

James Bickett

21-31-10-38-17

FRANCIS

PROBABLE DOWNING

CAR OVERTURNED IN EXERC

Pinning Boy Down

BUREAU V. 8

JAN 5 1956

RECEIVED

**INSTRUCTIONS**

**1**

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

11889

Item 21 Film G190;12-20-55 ams

11894

# CERTIFICATE OF DEATH

Reg. Dist. No. 100

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
COUNTY <u>Charles</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Charles</u>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (In this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <u>La Plata</u>				TOWN <u>Fenwick</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Physicians Memorial Hospital</u>				STREET ADDRESS (If rural give location)			
<b>3. NAME OF DECEASED</b> (First) (Middle) (Last)				<b>4. DATE OF DEATH</b> (Month) (Day) (Year)			
<u>Annie B. Schuyler</u>				<u>Dec. 5 1955</u>			
<b>5. SEX</b>	<b>6. COLOR OR RACE</b>	<b>7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)</b>	<b>8. DATE OF BIRTH</b>	<b>9. AGE last birthday</b>	<b>IF UNDER 1 YEAR</b>		<b>IF UNDER 24 HRS.</b>
<u>Female</u>	<u>white</u>	<u>widowed</u>	<u>Oct. 20, 1862</u>	<u>93</u> yrs.	Months	Days	Hours Min.
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired)		<b>10b. KIND OF BUSINESS OR INDUSTRY</b>		<b>11. BIRTHPLACE</b> (State or foreign country)		<b>12. CITIZEN OF WHAT COUNTRY?</b>	
<u>Housewife</u>				<u>Conn.</u>		<u>US</u>	
<b>13. FATHER'S NAME</b>				<b>14. MOTHER'S MAIDEN NAME</b>			
<u>UNK.</u>				<u>UNK.</u>			
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unk.)		<b>16. SOCIAL SECURITY NO.</b>		<b>17. INFORMANT &amp; ADDRESS</b>			
<u>no</u>		<u>none</u>		<u>Mrs Roy Homan</u> <u>6412 Gull Rd, S.E. Wash. 22, D. C.</u>			
<b>I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>						<b>18. MEDICAL CERTIFICATION</b>	
<b>904.0 IMMEDIATE CAUSE</b> (A) <u>Cardio vascular Collapse</u>						INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSE(S) DUE TO						<u>12-5-55</u>	
<b>DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE</b> (B) <u>Long period of debilitation</u>							
STATING UNDERLYING CAUSE LAST. DUE TO						<u>11-18-55</u>	
(C) <u>Fractured hip</u>							
<b>II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.</b>							
<b>19a. DATE OF OPERATION</b>		<b>19b. MAJOR FINDINGS OF OPERATION</b>				<b>20. AUTOPSY?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
<b>21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH</b> (IF EITHER, NOTIFY MEDICAL EXAMINER)		<b>21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)</b>		<b>21c. WHERE DID INJURY OCCUR?</b> (City or town) (County) (State)			
		<u>Home</u>		<u>Fenwick</u> <u>Charles</u> <u>Md.</u>			
<b>21d. TIME OF INJURY</b> (Month) (Day) (Year) (Hour)		<b>21e. INJURY OCCURRED</b> While <input checked="" type="checkbox"/> Not while <input type="checkbox"/> el work el work		<b>21f. HOW DID INJURY OCCUR?</b>			
<u>Nov. 18 '55</u> A.M.				<u>Patient fell while tending to stove</u>			
<b>22. I hereby certify that I attended the deceased from....., 19....., to....., 19....., that I last saw the deceased alive on....., 19....., and that death occurred at..... from the causes and on the date stated above.</b>							
<b>SIGNATURE</b>				<b>ADDRESS</b> (Street, city, town, state)		<b>DATE SIGNED</b>	
<u>Frederick M. Johnson M.D.</u>				<u>La Plata, Md.</u>		<u>12-6-55</u>	
<b>23. BURIAL, CREMATION, REMOVAL (SPECIFY)</b>		<b>DATE THEREOF</b>		<b>NAME OF CEMETERY OR CREMATORY</b>		<b>LOCATION (City, town, or county) (State)</b>	
<u>Burial</u>		<u>12-6-1955</u>		<u>Bumpy Oak</u>		<u>Pomonkey, Maryland</u>	
<b>24. REC'D BY REGISTRAR</b>		<b>REGISTRAR'S SIGNATURE</b>		<b>25. FUNERAL DIRECTOR'S SIGNATURE</b>		<b>ADDRESS</b>	
DATE <u>12/7/55</u>		<u>Julia H. Passey</u>		<u>The Hunt Funeral Home</u>		<u>Waldorf, Md.</u>	

1. In the event of a death, the coroner or medical examiner shall cause a death certificate to be filed in the office of the registrar of vital statistics, who shall cause the same to be entered in the official records of the state. The death certificate shall be filed in the office of the registrar of vital statistics within a reasonable time after the death.

# CERTIFICATE OF DEATH

1. NAME OF DECEASED (PRINT OR TYPE)

2. SEX (M or F)

3. AGE (PRINT OR TYPE)

4. DATE OF BIRTH (PRINT OR TYPE)

5. PLACE OF BIRTH (PRINT OR TYPE)

6. OCCUPATION (PRINT OR TYPE)

7. CAUSE OF DEATH (PRINT OR TYPE)

8. MANNER OF DEATH (PRINT OR TYPE)

9. SIGNATURE OF REGISTRAR (PRINT OR TYPE)

10. DATE OF DEATH (PRINT OR TYPE)

11. PLACE OF DEATH (PRINT OR TYPE)

12. SIGNATURE OF CORONER OR MEDICAL EXAMINER (PRINT OR TYPE)

13. DATE OF SIGNATURE (PRINT OR TYPE)

14. PLACE OF SIGNATURE (PRINT OR TYPE)

15. SIGNATURE OF WITNESS (PRINT OR TYPE)

16. DATE OF SIGNATURE (PRINT OR TYPE)

17. PLACE OF SIGNATURE (PRINT OR TYPE)

18. SIGNATURE OF WITNESS (PRINT OR TYPE)

19. DATE OF SIGNATURE (PRINT OR TYPE)

20. PLACE OF SIGNATURE (PRINT OR TYPE)

21. SIGNATURE OF WITNESS (PRINT OR TYPE)

22. DATE OF SIGNATURE (PRINT OR TYPE)

23. PLACE OF SIGNATURE (PRINT OR TYPE)

24. SIGNATURE OF WITNESS (PRINT OR TYPE)

25. DATE OF SIGNATURE (PRINT OR TYPE)

26. PLACE OF SIGNATURE (PRINT OR TYPE)

27. SIGNATURE OF WITNESS (PRINT OR TYPE)

28. DATE OF SIGNATURE (PRINT OR TYPE)

29. PLACE OF SIGNATURE (PRINT OR TYPE)

30. SIGNATURE OF WITNESS (PRINT OR TYPE)

31. DATE OF SIGNATURE (PRINT OR TYPE)

32. PLACE OF SIGNATURE (PRINT OR TYPE)

33. SIGNATURE OF WITNESS (PRINT OR TYPE)

34. DATE OF SIGNATURE (PRINT OR TYPE)

35. PLACE OF SIGNATURE (PRINT OR TYPE)

36. SIGNATURE OF WITNESS (PRINT OR TYPE)

37. DATE OF SIGNATURE (PRINT OR TYPE)

38. PLACE OF SIGNATURE (PRINT OR TYPE)

39. SIGNATURE OF WITNESS (PRINT OR TYPE)

40. DATE OF SIGNATURE (PRINT OR TYPE)

41. PLACE OF SIGNATURE (PRINT OR TYPE)

BUREAU V. S.

RECEIVED

DEC 9 1935



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

11895  
 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. 11890  
 No. 100

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Charles</u>		MARYLAND		STATE <u>Md</u>		COUNTY <u>Charles</u>	
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (In this place)		CITY (If outside corporate limits write RURAL and give nearest town)		OR TOWN	
<u>X</u> TOWN <u>Welcome</u> (rural)		<u>life</u>		TOWN <u>Welcome</u>		<u>X</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural, give location)			
<u>00</u>				<u>rural</u>			
3. NAME OF DECEASED: (First)		(Middle)		(Last)		4. DATE OF DEATH (Month) (Day) (Year)	
<u>EMMA J. SHORT</u>						<u>Dec. 2 1955</u>	
5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH:	9. AGE last birthday:	IF UNDER 1 YEAR		IF UNDER 24 HRS.
<u>F</u>	<u>negro</u>	<u>Widowed</u>	<u>Nov. 14 1890</u>	<u>65</u> yrs.	Months	Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country):		12. CITIZEN OF WHAT COUNTRY?	
<u>house work</u>		<u>self</u>		<u>Charles Co.</u>		<u>US</u>	
13. FATHER'S NAME:				14. MOTHER'S MAIDEN NAME:			
<u>John Jordon</u>				<u>Sarah Johnson</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY No.:		17. INFORMANT & ADDRESS:			
<u>no</u>		<u>no</u>		<u>William Jordon, Hill Top, Md.</u>			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:						<u>12-2-55</u>	
<u>420.1</u> Immediate cause (a)..... DUE TO <u>Coronary Occlusion</u>							
Antecedent cause(s) (b)..... Diseases or conditions, if any, giving rise to the above cause DUE TO stating underlying cause last (c)							
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION:				19b. MAJOR FINDING OF OPERATION:			
<u>0</u>							
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY		21c. (City or town) (County) (State)		20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>	
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
SIGNATURE		CHIEF MEDICAL EXAMINER		DEPUTY MEDICAL EXAMINER		DATE SIGNED	
<u>[Signature]</u>		<u>[Signature]</u>		<u>[Signature]</u>		<u>12-2-55</u>	
23. BURIAL, CREMATION, REMOVAL (Specify):		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>Dec. 4 1955</u>		<u>Zion Baptist Cemetery</u>		<u>Welcome, Md.</u>	
DATE REC'D BY LOCAL REG.		REGISTRAR'S SIGNATURE		24. FUNERAL DIRECTOR		ADDRESS	
<u>12/3/55</u>		<u>[Signature]</u>		<u>Huntt Funeral Home</u>		<u>Waldorf, Md.</u>	

BUREAU V. S.

DEC 6 1955

RECEIVED

1

INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

11892

11896

## CERTIFICATE OF DEATH

Reg. Dist. No. 100

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
COUNTY <i>Charles</i>		MARYLAND		STATE <i>md</i>		COUNTY <i>Charles</i>	
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <i>Bel Air</i>				TOWN <i>Bel Air</i>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
<i>Robert Andrew Welch</i>				<i>Dec 7 1953</i>			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR	IF UNDER 24 HRS.	
<i>M</i>	<i>White</i>	<i>Married</i>	<i>July 4, 1909</i>	<i>46</i> yrs.	Months	Days	Hours
10a. USUAL OCCUPATION (Give kind of work done during most of working life; even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
<i>Carpenter</i>				<i>Maryland</i>		<i>USA</i>	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
<i>Dison Welch</i>				<i>Susie Della</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
<i>No</i>		<i>214-12-7154</i>		<i>John A Welch</i>			
<b>I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>				<b>18. MEDICAL CERTIFICATION</b>			
443X IMMEDIATE CAUSE (A)				<i>Coronary Thrombosis</i>			
ANTECEDENT CAUSE(S) DUE TO				<i>Hypertensive Cardiovascular</i>			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.				<i>Disease</i>			
				<i>Arterio Sclerosis</i>			
19a. DATE OF OPERATION				19b. MAJOR FINDINGS OF OPERATION			
<i>None</i>							
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, or INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town)		(County) (State)	
		<i>Home</i>		<i>Home</i>			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While at work Not while at work		21f. HOW DID INJURY OCCUR?			
		<input type="checkbox"/> <input checked="" type="checkbox"/>					
22. I hereby certify that I attended the deceased from <i>11/4</i> , 19 <i>53</i> , to <i>12-7</i> , 19 <i>53</i> , that I last saw the deceased alive on <i>11/30</i> , 19 <i>53</i> , and that death occurred at <i>6 A</i> M, from the causes and on the date stated above.							
SIGNATURE				ADDRESS (Street, city, town, state)			
<i>William H. Kuss</i>				<i>La Plata</i>			
M.D.				DATE SIGNED			
				<i>12/8/53</i>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county)	
<i>Burial</i>		<i>12-10-53</i>		<i>Good Hope</i>		<i>Newburg</i>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
<i>Julia H. Passey</i>		<i>Julia H. Passey</i>		<i>Clifford Funeral Home</i>		<i>La Plata</i>	
DATE <i>12/10/53</i>							

## 2281

U. S. BUREAU

DEC 13 1955

RECEIVED

1

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

11893

## CERTIFICATE OF DEATH

11897

Reg. Dist. No. 105

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
COUNTY <u>CHARLES</u>		STATE <u>MARYLAND</u> COUNTY <u>CHARLES</u>		CITY (If outside corporate limits, write RURAL and give nearest town)		CITY (If outside corporate limits, write RURAL and give nearest town)	
CITY OR TOWN <u>Rural: WALDORF</u>		LENGTH OF STAY (in this place)		CITY OR TOWN <u>Rural: WALDORF</u>		STREET ADDRESS (If rural give location)	
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS			
<b>3. NAME OF DECEASED</b> (First) <u>Susan</u> (Middle) <u>WELCH</u> (Last)				<b>4. DATE OF DEATH</b> (Month) <u>Dec</u> (Day) <u>28</u> (Year) <u>55</u>			
<b>5. SEX</b> <u>Female</u>	<b>6. COLOR OR RACE</b> <u>white</u>	<b>7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)</b>	<b>8. DATE OF BIRTH</b> <u>Feb 15 1875</u>	<b>9. AGE last birthday</b> <u>80</u> yrs.	<b>IF UNDER 1 YEAR</b> Months Days	<b>IF UNDER 24 HRS.</b> Hours Min.	
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>housewife</u>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>domestic</u>		<b>11. BIRTHPLACE</b> (State or foreign country) <u>Maryland</u>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>U.S.</u>	
<b>13. FATHER'S NAME</b> <u>John J. Welch</u>				<b>14. MOTHER'S MAIDEN NAME</b> <u>Mary E. Davis</u>			
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, give war or dates of service) <u>no</u>		<b>16. SOCIAL SECURITY NO.</b> <u>none</u>		<b>17. INFORMANT &amp; ADDRESS</b> <u>Henry J. Welch Waldorf md</u>			
<b>I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>						<b>18. MEDICAL CERTIFICATION</b>	
<b>331X IMMEDIATE CAUSE (A)</b> <u>Respiratory Collapse</u>						<b>INTERVAL BETWEEN ONSET AND DEATH</b> <u>20 min</u>	
<b>ANTECEDENT CAUSE(S) DUE TO (B)</b> <u>Cerebral vascular accident</u>						<u>46 hrs</u>	
<b>DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)</b> <u>Senile vascular changes</u>						<u>5 years.</u>	
<b>II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.</b> <u>Arthritis</u>						<u>20 years.</u>	
<b>19a. DATE OF OPERATION</b>		<b>19b. MAJOR FINDINGS OF OPERATION</b>		<b>20. AUTOPSY?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
<b>21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)</b>		<b>21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)</b>		<b>21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)</b>			
<b>21d. TIME OF INJURY (Month) (Day) (Year) (Hour)</b>		<b>21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/></b>		<b>21f. HOW DID INJURY OCCUR?</b>			
<b>22. I hereby certify that I attended the deceased from <u>January</u>, 19 <u>55</u>, to <u>28 Dec</u>, 19 <u>55</u>, that I last saw the deceased alive on <u>28 Dec</u>, 19 <u>55</u>, and that death occurred at <u>6:10 P.M.</u> from the causes and on the date stated above.</b>							
<b>SIGNATURE</b> <u>Dr. Wooddy</u>		<b>M.D.</b> <u>La Plata, Md.</u>		<b>DATE SIGNED</b> <u>28 Dec 55</u>			
<b>23. BURIAL, CREMATION, REMOVAL (SPECIFY)</b> <u>Burial</u>		<b>DATE THEREOF</b> <u>12-31-55</u>		<b>NAME OF CEMETERY OR CREMATORY</b> <u>Oakland</u>		<b>LOCATION (City, town, or county) (State)</b> <u>Waldorf Md</u>	
<b>24. REC'D BY REGISTRAR</b> <u>12/31/55</u>		<b>REGISTRAR'S SIGNATURE</b> <u>M. L. Mow</u>		<b>25. FUNERAL DIRECTOR'S SIGNATURE</b> <u>Honth Funeral Home</u>		<b>ADDRESS</b> <u>Waldorf Md</u>	

## INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filled with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M



# CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, MD.

Form 100-100

1. THE DEATH OF THE DECEASED

2. PLACE OF DEATH

3. DATE OF DEATH

4. NAME OF DECEASED

5. SEX

6. AGE

7. RACE

8. OCCUPATION

9. CAUSE OF DEATH

10. MANNER OF DEATH

11. SIGNATURE OF PHYSICIAN

12. SIGNATURE OF WITNESSES

13. SIGNATURE OF DECEASED

14. SIGNATURE OF BURIAL OFFICIAL

15. SIGNATURE OF REGISTRAR

16. SIGNATURE OF CLERK

17. SIGNATURE OF JURY

18. SIGNATURE OF COURT

19. SIGNATURE OF STATE

20. SIGNATURE OF NATION

21. SIGNATURE OF WORLD

22. SIGNATURE OF UNIVERSE

23. SIGNATURE OF GOD

24. SIGNATURE OF HEAVEN

25. SIGNATURE OF EARTH

26. SIGNATURE OF WATER

27. SIGNATURE OF FIRE

28. SIGNATURE OF AIR

29. SIGNATURE OF LIGHT

30. SIGNATURE OF DARKNESS

31. SIGNATURE OF LIFE

32. SIGNATURE OF DEATH

33. SIGNATURE OF HOPE

34. SIGNATURE OF FEAR

35. SIGNATURE OF LOVE

36. SIGNATURE OF HATE

37. SIGNATURE OF KINDNESS

38. SIGNATURE OF CRUELTY

39. SIGNATURE OF GENTLENESS

40. SIGNATURE OF RAGE

41. SIGNATURE OF MILDNESS

42. SIGNATURE OF PRIDE

43. SIGNATURE OF HUMILITY

44. SIGNATURE OF ENVY

45. SIGNATURE OF JEALOUSY

46. SIGNATURE OF CHARITY

47. SIGNATURE OF GREED

48. SIGNATURE OF SLAVENRY

49. SIGNATURE OF FREEDOM

50. SIGNATURE OF DEATH

51. SIGNATURE OF LIFE

52. SIGNATURE OF HOPE

53. SIGNATURE OF FEAR

54. SIGNATURE OF LOVE

55. SIGNATURE OF HATE

56. SIGNATURE OF KINDNESS

57. SIGNATURE OF CRUELTY

58. SIGNATURE OF GENTLENESS

59. SIGNATURE OF RAGE

60. SIGNATURE OF MILDNESS

61. SIGNATURE OF PRIDE

62. SIGNATURE OF HUMILITY

63. SIGNATURE OF ENVY

64. SIGNATURE OF JEALOUSY

65. SIGNATURE OF CHARITY

66. SIGNATURE OF GREED

67. SIGNATURE OF SLAVENRY

68. SIGNATURE OF FREEDOM

69. SIGNATURE OF DEATH

70. SIGNATURE OF LIFE

71. SIGNATURE OF HOPE

72. SIGNATURE OF FEAR

73. SIGNATURE OF LOVE

74. SIGNATURE OF HATE

75. SIGNATURE OF KINDNESS

76. SIGNATURE OF CRUELTY

77. SIGNATURE OF GENTLENESS

78. SIGNATURE OF RAGE

79. SIGNATURE OF MILDNESS

80. SIGNATURE OF PRIDE

81. SIGNATURE OF HUMILITY

82. SIGNATURE OF ENVY

83. SIGNATURE OF JEALOUSY

84. SIGNATURE OF CHARITY

85. SIGNATURE OF GREED

86. SIGNATURE OF SLAVENRY

87. SIGNATURE OF FREEDOM

88. SIGNATURE OF DEATH

89. SIGNATURE OF LIFE

90. SIGNATURE OF HOPE

91. SIGNATURE OF FEAR

92. SIGNATURE OF LOVE

93. SIGNATURE OF HATE

94. SIGNATURE OF KINDNESS

95. SIGNATURE OF CRUELTY

96. SIGNATURE OF GENTLENESS

97. SIGNATURE OF RAGE

98. SIGNATURE OF MILDNESS

99. SIGNATURE OF PRIDE

100. SIGNATURE OF HUMILITY

101. SIGNATURE OF ENVY

102. SIGNATURE OF JEALOUSY

103. SIGNATURE OF CHARITY

104. SIGNATURE OF GREED

105. SIGNATURE OF SLAVENRY

106. SIGNATURE OF FREEDOM

107. SIGNATURE OF DEATH

108. SIGNATURE OF LIFE

109. SIGNATURE OF HOPE

110. SIGNATURE OF FEAR

111. SIGNATURE OF LOVE

112. SIGNATURE OF HATE

113. SIGNATURE OF KINDNESS

114. SIGNATURE OF CRUELTY

115. SIGNATURE OF GENTLENESS

116. SIGNATURE OF RAGE

117. SIGNATURE OF MILDNESS

118. SIGNATURE OF PRIDE

119. SIGNATURE OF HUMILITY

120. SIGNATURE OF ENVY

121. SIGNATURE OF JEALOUSY

122. SIGNATURE OF CHARITY

123. SIGNATURE OF GREED

124. SIGNATURE OF SLAVENRY

125. SIGNATURE OF FREEDOM

126. SIGNATURE OF DEATH

127. SIGNATURE OF LIFE

128. SIGNATURE OF HOPE

129. SIGNATURE OF FEAR

130. SIGNATURE OF LOVE

131. SIGNATURE OF HATE

132. SIGNATURE OF KINDNESS

133. SIGNATURE OF CRUELTY

134. SIGNATURE OF GENTLENESS

135. SIGNATURE OF RAGE

136. SIGNATURE OF MILDNESS

137. SIGNATURE OF PRIDE

138. SIGNATURE OF HUMILITY

139. SIGNATURE OF ENVY

140. SIGNATURE OF JEALOUSY

141. SIGNATURE OF CHARITY

142. SIGNATURE OF GREED

143. SIGNATURE OF SLAVENRY

144. SIGNATURE OF FREEDOM

145. SIGNATURE OF DEATH

146. SIGNATURE OF LIFE

147. SIGNATURE OF HOPE

148. SIGNATURE OF FEAR

149. SIGNATURE OF LOVE

150. SIGNATURE OF HATE

151. SIGNATURE OF KINDNESS

152. SIGNATURE OF CRUELTY

153. SIGNATURE OF GENTLENESS

154. SIGNATURE OF RAGE

155. SIGNATURE OF MILDNESS

156. SIGNATURE OF PRIDE

157. SIGNATURE OF HUMILITY

158. SIGNATURE OF ENVY

159. SIGNATURE OF JEALOUSY

160. SIGNATURE OF CHARITY

161. SIGNATURE OF GREED

162. SIGNATURE OF SLAVENRY

163. SIGNATURE OF FREEDOM

164. SIGNATURE OF DEATH

165. SIGNATURE OF LIFE

166. SIGNATURE OF HOPE

167. SIGNATURE OF FEAR

168. SIGNATURE OF LOVE

169. SIGNATURE OF HATE

170. SIGNATURE OF KINDNESS

171. SIGNATURE OF CRUELTY

172. SIGNATURE OF GENTLENESS

173. SIGNATURE OF RAGE

174. SIGNATURE OF MILDNESS

175. SIGNATURE OF PRIDE

176. SIGNATURE OF HUMILITY

177. SIGNATURE OF ENVY

178. SIGNATURE OF JEALOUSY

179. SIGNATURE OF CHARITY

180. SIGNATURE OF GREED

181. SIGNATURE OF SLAVENRY

182. SIGNATURE OF FREEDOM

183. SIGNATURE OF DEATH

184. SIGNATURE OF LIFE

185. SIGNATURE OF HOPE

186. SIGNATURE OF FEAR

187. SIGNATURE OF LOVE

188. SIGNATURE OF HATE

189. SIGNATURE OF KINDNESS

190. SIGNATURE OF CRUELTY

191. SIGNATURE OF GENTLENESS

192. SIGNATURE OF RAGE

193. SIGNATURE OF MILDNESS

194. SIGNATURE OF PRIDE

195. SIGNATURE OF HUMILITY

196. SIGNATURE OF ENVY

197. SIGNATURE OF JEALOUSY

198. SIGNATURE OF CHARITY

199. SIGNATURE OF GREED

200. SIGNATURE OF SLAVENRY

201. SIGNATURE OF FREEDOM

202. SIGNATURE OF DEATH

203. SIGNATURE OF LIFE

204. SIGNATURE OF HOPE

205. SIGNATURE OF FEAR

206. SIGNATURE OF LOVE

207. SIGNATURE OF HATE

208. SIGNATURE OF KINDNESS

209. SIGNATURE OF CRUELTY

210. SIGNATURE OF GENTLENESS

211. SIGNATURE OF RAGE

212. SIGNATURE OF MILDNESS

213. SIGNATURE OF PRIDE

214. SIGNATURE OF HUMILITY

215. SIGNATURE OF ENVY

216. SIGNATURE OF JEALOUSY

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219. SIGNATURE OF SLAVENRY

220. SIGNATURE OF FREEDOM

221. SIGNATURE OF DEATH

222. SIGNATURE OF LIFE

223. SIGNATURE OF HOPE

224. SIGNATURE OF FEAR

225. SIGNATURE OF LOVE

226. SIGNATURE OF HATE

227. SIGNATURE OF KINDNESS

228. SIGNATURE OF CRUELTY

229. SIGNATURE OF GENTLENESS

230. SIGNATURE OF RAGE

231. SIGNATURE OF MILDNESS

232. SIGNATURE OF PRIDE

233. SIGNATURE OF HUMILITY

234. SIGNATURE OF ENVY

235. SIGNATURE OF JEALOUSY

236. SIGNATURE OF CHARITY

237. SIGNATURE OF GREED

238. SIGNATURE OF SLAVENRY

239. SIGNATURE OF FREEDOM

240. SIGNATURE OF DEATH

241. SIGNATURE OF LIFE

242. SIGNATURE OF HOPE

243. SIGNATURE OF FEAR

244. SIGNATURE OF LOVE

245. SIGNATURE OF HATE

246. SIGNATURE OF KINDNESS

247. SIGNATURE OF CRUELTY

248. SIGNATURE OF GENTLENESS

249. SIGNATURE OF RAGE

250. SIGNATURE OF MILDNESS

251. SIGNATURE OF PRIDE

252. SIGNATURE OF HUMILITY

253. SIGNATURE OF ENVY

254. SIGNATURE OF JEALOUSY

255. SIGNATURE OF CHARITY

256. SIGNATURE OF GREED

257. SIGNATURE OF SLAVENRY

258. SIGNATURE OF FREEDOM

1

INSTRUCTIONS

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VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

12580

11898

## CERTIFICATE OF DEATH

Reg. Dist. No. 103

Items 1, 2, Film 191 1-21-56 et

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <i>Charles</i>		MARYLAND		STATE <i>md</i>		COUNTY <i>Charles</i>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (In this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
X TOWN <i>La Plata</i>				TOWN <i>La Plata</i>		X	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <i>R.F.D.</i>				STREET ADDRESS (If rural give location) <i>R.F.D.</i>			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) <i>Susie</i> (Middle) <i>E.</i> (Last) <i>Welch</i>				(Month) <i>12</i> (Day) <i>27</i> (Year) <i>1955</i>			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR		IF UNDER 24 HRS.
<i>Female</i>	<i>white</i>	<i>married</i>	<i>March 30, 1884</i>	<i>71</i> yrs.	Months	Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
<i>H.W.</i>				<i>Maryland</i>		<i>U.S.A.</i>	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
<i>Luther M. Della</i>				<i>Angelina Osborn</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
				<i>Francis W. Welch</i> <i>Buyers Rd</i>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH	
490X IMMEDIATE CAUSE (A)				<i>Labor &amp; Puerperia</i>		<i>12-22-55</i>	
ANTECEDENT CAUSE(S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)				<i>Congestive Failure</i>		<i>1954</i>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.				<i>Septicemia St. Dissem</i>		<i>1945</i>	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town)		(County) (State)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M.		21a. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <i>1945</i> , 19 <i>12-27-55</i> , to <i>12-27-55</i> , that I last saw the deceased alive on <i>12-27</i> , 19 <i>55</i> and that death occurred at <i>La Plata</i> , Md., from the causes and on the date stated above.							
SIGNATURE <i>E. Edelman</i>				ADDRESS (Street, city, town, state) <i>La Plata Md.</i>		DATE SIGNED <i>12-27-55</i>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<i>Burial</i>		<i>12/30/55</i>		<i>Good Hope</i>		<i>Newburg Md.</i>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
DATE <i>1-2-56</i>		<i>Julia H. Breen</i>		<i>Rehoboth Funeral Home La Plata Md.</i>			

